Partner Relations and AIDS in Chiang Mai Villages

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Except where otherwise indicated, the work in this thesis is my own, and is based on original research performed at the Australian National University.

Wassana Im-Em

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ABSTRACT

Heterosexual transmission is a major element in the AIDS epidemic in Thailand which is severest in the Upper-North region. There has been a continued rise in the prevalence of HIV infection among low-risk populations there. To limit the spread of AIDS, it is necessary to identify the factors that have caused Thai men to have multiple sex partners and to explain why prostitute patronage is persisting despite the existence of AIDS.

This study explores the socio-cultural factors which influence partner relations and sexual contacts among the people in the rural areas of Chiang Mai. In 1993, 39 men and women were selected for life history reviews to gain insights into the nature and patterns of sexual behaviour. Subsequently, 600 men and women were randomly selected from 12 villages for face-to-face interviews. Two of these villages were also selected for participant observation, and 12 group discussions were conducted there.

This study found that, before 1960, prostitution was not prevalent among the peasants in rural Chiang Mai. Belief in supernatural punishment influenced sexual behaviour then; men and women were expected to have sex with their partners only after marriage, and to maintain monogamous relationship thereafter. However, during the last two decades, several socio-economic changes have occurred in the society, and the beliefs, attitudes and practices relating to sex have changed considerably.

It is now generally accepted that men first gain sexual experience with prostitutes, but women should abstain from sex before marriage. About 80 per cent of men have ever had sex with prostitutes, and only about half abstain from sexual contact with prostitutes after marriage. Several factors within marriage explain why married men pay for sex, including decreased coital frequency with increased age and marriage duration, problems of sexual relations with spouse and sexual abstinence related to childbirth.

One of the important findings in this study is that Thais believe that men should not restrain their sexual partnerships but women should restrict themselves to their marriage partners. Furthermore, beliefs about sterilisation, traditional sexual operations and perceptions about sexuality support the notion that women should be sexually passive even with their husbands which encourages men's contact with prostitutes and can increase AIDS risk.

High awareness about AIDS has led in recent years to a declining number of men having sex with prostitutes. However, about one-third of single men still do not abstain from sexual contact with prostitutes. The unbalanced marriage market additionally explains why single men seek sexual contact with prostitutes. The out-migration of rural women arising partly from the increased education of women, together with the division of

society into classes according to socio-economic status, subsequently limits choice in partner selection of men from the low social class. Whether or not AIDS treatment becomes available in the future, men who have difficulty in finding a long-term partner will continue to have sexual contact with prostitutes. The current focus of AIDS prevention is on condom use but what should be added for the long-term prevention is that men's and women's attitudes to sex need to be changed and also relationships within unions and upholding family values need to be promoted.

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CHAPTER 1
Background of the Study

This descriptive study explores partner relations of people in the rural area of the northern part of Thailand for the development of anti-AIDS planning. The focus is on the socio-cultural factors which influence the sexual relations of the people. The rural areas of Chiang Mai province were selected as study sites. This chapter gives general information about Chiang Mai province and the emergence of AIDS in the area. Some major socio-economic factors of Thailand are explored to provide background information about the recent changes in the country. The rationale for the study is discussed along with research questions and objectives of the study. A summary of the AIDS epidemic in Thailand is given in detail in Chapter 2.

1.1 CHIANG MAI AND THE NORTH OF THAILAND

Chiang Mai, about 700 kilometres north of Bangkok, is one of the largest provinces in Thailand and the biggest city among 17 northern provinces. The northernmost district of Chiang Mai shares a border with southeastern Myanmar. Its population was 1.37 million in the 1990 census enumeration and 88 per cent of them lived in rural areas. About 59 per cent of the people were engaged in agriculture. Chiang Mai city has been a well-known tourist destination for local and foreign tourists for many decades. Tourism and manufactured products are the major sources of income for the people of this province (National Statistical Office, 1990: Table C).

1.1.1 History of Chiang Mai

Chiang Mai was once a self-governing state with its own culture. It is the old capital of the Lanna kingdom which comprises eight contemporary provinces of Thailand: Chiang Mai, Chiang Rai, Lamphun, Lampang, Phrae, Nan, Payao and Mae Hong Son. It was built about 700 years ago at the same period as Sukothai, the first capital of Thailand. The kingdom was well developed and maintained its culture until it was united to Burma in the year 1558 for 200 years. Much of the contemporary art and culture of Chiang Mai shows the assimilation between the Lanna and Burmese influences. Lanna became a colony of Thailand in the year 1774 but the kingdom retained its administration and its rulers. It was incorporated as an administrative part of Thailand in 1868 during the period when Western powers successfully invaded many Southeast Asian countries. Chiang Mai no longer had its monarchy after 1939; it became a province of Thailand in 1933 (Soonthonphesat, 1970; Vichienkeaw, 1978).

The people from this traditional Lanna kingdom still regard themselves as different from the Thai people. Their dialect and some of their customs are different from those of other regions of Thailand. Throughout this thesis, the term Upper-North provinces is

used in referring to the provinces of Thailand which used to belong to the Lanna kingdom. People of these provinces refer to themselves as *khon muang*, which is different from *khon Thai* or Thai people.[1]

1.1.2 AIDS Epidemic in the North of Thailand

People with AIDS have been found in every province of Thailand with the highest reports in the Upper-North region as shown in Table 1.1 and Figure 1.1. There was a total of 7,454 cumulative AIDS cases throughout the country as reported by December 1993. About 56 per cent were in the Northern region, 16 per cent in the Central region excluding Bangkok, 15 per cent in Bangkok, nine per cent in the Northeast region and four per cent in the Southern region. However, AIDS cases reported in Chiang Mai and Chiang Rai provinces alone constitute one-third of the nation's figure (Division of Epidemiology, 1993).

Table 1.1 Ten provinces with highest cumulative number of AIDS cases reported by December 1993

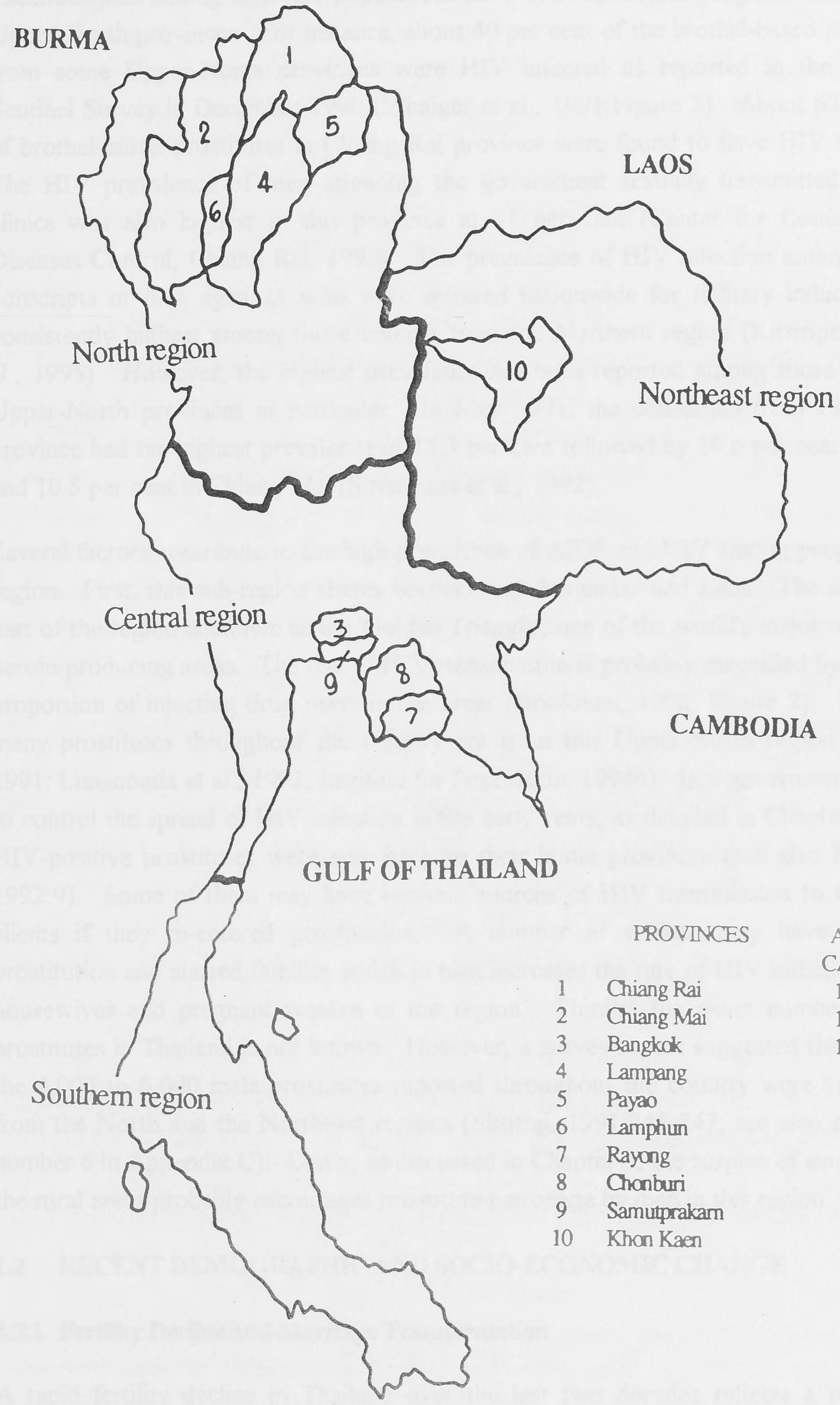
Province	Region	AIDS cases	% [a]	Per 100,000 population in 1990
1. Chiang Rai	Upper-North	1340	18.0	127
2. Chiang Mai	Upper-North	1205	16.0	88
3. Bangkok	Central	1115	15.0	19
4. Lampang	Upper-North	487	6.5	67
5. Payao	Upper-North	345	4.6	73
6. Lamphun	Upper-North	279	3.7	68
7. Rayong	Central	131	1.8	29
8. Chonburi	Central	127	1.7	15
9. Samutprakarn	Central	117	1.5	15
10. Khon Kaen	Northeast	105	1.4	6

[a] Denominator is 7,454 AIDS cases reported throughout Thailand by December 1993.

Sources: Division of Epidemiology, Ministry of Health, December 1993
National Statistical Office, 1992: Table 1

1. There are several ways of transcribing Thai scripts into Roman script. Throughout this thesis, Thai scripts are written in Roman script following the Library of Congress Reference (1977).

Figure 1.1 Ten provinces with highest cumulative number of AIDS cases reported by December 1993



	PROVINCES	AIDS CASES
1	Chiang Rai	1340
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3	Bangkok	1115
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10	Khon Kaen	105

The actual number of Thai people with HIV infection is not known: however, the HIV infection rates among high-risk populations have been consistently highest among these Upper-North provinces. For instance, about 40 per cent of the brothel-based prostitutes from some Upper-North provinces were HIV infected as reported in the National Sentinel Survey in December 1990 (Weniger et al., 1991:Figure 3). About 63 per cent of brothel-based prostitutes in Chiang Rai province were found to have HIV that year. The HIV prevalence of men attending the government sexually transmitted diseases clinics was also highest in this province at 31 per cent (Center for Communicable Diseases Control, Chiang Rai, 1992). The prevalence of HIV infection among 30,000 conscripts or men aged 21 who were selected nationwide for military induction was consistently highest among those coming from the Northern region (Kitsiripornchai et al., 1995). However, the highest prevalence has been reported among those from the Upper-North provinces in particular. In May 1991, the conscripts from Chiang Rai province had the highest prevalence of 15.3 per cent followed by 10.6 per cent in Payao and 10.5 per cent in Chiang Mai (Sirisopana et al., 1992).

Several factors contribute to the high prevalence of AIDS and HIV among people in this region. First, this sub-region shares borders with Myanmar and Laos. The uppermost part of the region is known as the 'Golden Triangle', one of the world's major opium and heroin producing areas. The risk of HIV transmission is probably magnified by the large proportion of injecting drug users in the areas (Brinkman, 1992: Figure 2). Secondly, many prostitutes throughout the country are from this Upper-North region (Sittitrai, 1991; Limanonda et al., 1993; Institute for Population, 1994b). In a government attempt to control the spread of HIV infection in the early years, as detailed in Chapter 2, many HIV-positive prostitutes were sent back to their home provinces (see also Brinkman, 1992:9). Some of them may have become sources of HIV transmission to their male clients if they re-entered prostitution. A number of women may have given up prostitution and started families which in turn increases the rate of HIV infection among housewives and pregnant women in the region. Thirdly, the exact number of male prostitutes in Thailand is not known. However, a survey report suggested that many of the 4,000 to 6,000 male prostitutes reported throughout the country were young men from the North and the Northeast regions (Sittitrai, 1991:245-247; see also case study number 6 in Appendix C). Lastly, as discussed in Chapter 5, the surplus of single men in the rural areas probably encourages prostitute patronage by men in this region.

1.2 RECENT DEMOGRAPHIC AND SOCIO-ECONOMIC CHANGE

1.2.1 Fertility Decline and Marriage Transformation

A rapid fertility decline in Thailand over the last two decades reflects a remarkable revolution in people's reproductive behaviour. The government's concern about the high rate of population growth began around 1960; however, it was not until 1970 that an official population policy was adopted with a National Family Planning Program

(National Economic and Social Development Board, 1990). The total fertility rate in the 1950s and early 1960s was about 6.5 (National Research Council, 1980). Two decades later, it had declined to 2.3 in 1987, and then reached replacement level of 2.2 in 1992 (Chayovan, Kamnuansilpa and Knodel 1988:Table 3.1; Institute for Population, 1992). The current total fertility rate is estimated to be below replacement level at 1.95 (Institute for Population, 1994a).

The fertility decline in Chiang Mai province has been the most rapid in the country. Contraception in Chiang Mai was initiated at the McCormick hospital by Dr. McDaniel long before the government first launched the family planning campaign. Women from selected areas of Chiang Mai were offered sterilisation in 1948, intra-uterine devices in 1963, injectables in 1965, and pills in 1967. To serve the demand of women in the rural areas, the mobile service offering pills and injectables in villages began in 1969 (Baldwin, 1978: 301). The introduction of contraception probably led to an early fertility decline in Chiang Mai. The crude birth rate dropped from about 40 in 1954 to less than 20 in 1973 (Padthaisong, 1978). In 1989, more than 80 per cent of Chiang Mai women aged between 15 and 49 were current users of a contraceptive method, which was nearly 20 per cent greater than the national prevalence at the time (Pawaphutanon, 1992). It is expected that Chiang Mai will reach zero population growth within the next decade because of the very low birth rate (Padthaisong, 1988:63).

The rapid fertility decline in Thailand is believed to be largely due to an increase in contraceptive use in the past decades (Knodel, Chamratrithirong and Debavalya, 1987). Contraceptive use prevalence has increased from 53 per cent in 1978 to 75 per cent in 1992 (Leoprapai and Thongthai, 1989:29; Institute for Population, 1992). Also, recent studies suggest that levels of non-marriage in Thailand have been increasing in the last three decades (Guest and Tan, 1994; Jones, 1995). The increase in the proportions of non-marriage and the increase in age at marriage will contribute to a further fertility decline in Thailand.

Delayed marriage and increased non-marriage have recently transformed marriage patterns in Thailand. Using the 1970 and 1980 censuses to analyse nuptiality trends among 17 Asian countries, Xenos and Gultiano (1992) pointed out that there is a rising trend in non-marriage among Thai women. However, the trend is not evident among Thai men. In agreement with this study, Guest and Tan (1994) analysed 1970 and 1990 census data and indicated that the proportions never-married among the Thai population aged between 30 and 44 increased substantially during this period. The increases were greatest for women who remain single into their 40s. Although there has been a substantial delaying of marriage for men until their early or late 30s, most of them eventually marry. Unmarried women are concentrated in the central provinces surrounding Bangkok while higher levels of unmarried men are observed in the Northern provinces (Guest and Tan, 1994: 7, 22). The percentage of unmarried women in Bangkok is reported to be the highest among many major cities in East and Southeast

Asia: nearly 30 per cent of women aged 30 to 34 in Bangkok remain unmarried, and the figure is higher than 40 per cent among those with tertiary education (Jones, 1995: Tables 2 and 3).

Thai women may delay marriage or wait for a suitable partner from their independence gained through urban employment. Female-dominated migration from rural to urban areas in Thailand in recent years has been associated with an increased demand of young women for modern sector employment (Guest, Richter and Archavanitkul, 1993). The yearly reports from the Labour Force Survey between 1988 and 1990 indicate that women outnumbered men in manufacturing, commerce and service work (National Statistical Office, 1992: Table 27). Besides modern-sector employment, young women are in large demand for domestic work as baby-sitters and housemaids as an increasing number of Thai women in the urban areas are now also taking employment like their husbands. The relatively high proportions of non-marriage among men in the Northern provinces may be related to the out-migration of women from these provinces (Guest and Tan, 1994: 22).

1.2.2 Higher Education Attainment for Both Sexes

The provision of education for women has greatly improved in the last two decades. Women are now as likely as men to continue secondary school beyond compulsory education (Knodel and Wongsith 1989). The number of women attending tertiary education institutions is rising and is close to the number of men. While the number of enrolments of women is close to that of men in tertiary education at public institutions, the enrolments of women include about 60 per cent in private institutions as recorded in academic years 1989 to 1990 (National Statistical Office, 1992: Table 59 and 60).[2]

Despite the efforts being made to bring higher education to those living in the rural areas, the rapid fertility decline over the past two decades has started to affect the provision of education in the rural areas. The effect is evident in Chiang Mai where fertility began to decline much earlier than in the rest of the country. More than 100 schools or nearly 10 per cent of the government primary schools in Chiang Mai were forced to close by 1988 because of lack of students. Another 100 schools could not operate with regular teaching: for instance, students in different levels were put together in the same class (Padthaisong 1988; Pawaphutanon 1992). This has resulted in poor quality of schooling in the rural areas: so with the support of their parents, an increasing number of students from rural areas have moved to towns for better education.

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2. The total number of enrolments at public institutions of tertiary education nationwide was about 550,000 and that for the private ones was about 80,000 in 1989 and 1990. The enrolments in public institutions were much larger than in private ones because the former include two open universities which contain 80 per cent of the enrolments at public institutions. When these two universities are excluded, the enrolment in public institutions is about 20,000 more than in private ones.

1.2.3 Urbanisation and Migration

Thailand has developed to become an industrialised country since 1960. Under the first National Development Plan, implemented in 1960, farmers were encouraged to plant cash crops and varieties of rice that produced high yields. However, pesticides and agricultural machinery were needed for this cash-crop farming; some farmers became successful in this revolution of farming, but many had to take up loans and some went bankrupt. A large number of them started to go to the cities seeking to supplement their income during the off-farming season. A number of them took employment as low-skilled workers in the Middle-East, starting in the 1970s. However, most of them took loans at high interest rates to cover the expense of going overseas. Casual employment in the big cities seems to be the only way that they could earn cash to repay the debts.

The expansion of urban areas in Thailand has increased rapidly as a consequence of the National Development Plan emphasising the promotion of the industrial and service sectors. The annual economic growth was claimed to be rising by 10.5 per cent during 1987 to 1991; the per capita income doubled within these five years. However, the income gap between the rich and the poor is increasing with urban growth: farmers remained the poorest, receiving only half of the average per capita income (National Economic and Social Board, 1991:1-3). To control the extreme growth of Bangkok, the government has developed industrial estates in peripheral areas of each region to promote regional growth; this has resulted in a rapid urban growth in every region. The level of rural to urban migration has doubled since 1970 (Archavanitkul, 1988). It is estimated that the proportion of the urban population in Thailand will increase from 20 per cent in 1985 to 49 per cent by the year 2025 (United Nations 1989: 302-303; 1990: 142-145).

1.2.4 Improved Health and Effect of AIDS

The general health of the Thai population has improved significantly. Most people have access to health services. More than 90 per cent of one-year-old children have been fully immunised (UNICEF, 1992: Table 3). The crude death rate has declined from 29 per thousand population between 1945 and 1949 to six per thousand population in 1994 (Prasithrathsint and Chareonkul, 1986:13-17; Institute for Population, 1994a). The infant mortality rate has declined from 132 per thousand live births between 1950 and 1955 to 34 per thousand live births in 1994. Since 1950, the longevity of Thai people has increased by 20 years on average: the life expectancy at birth has increased from 45 for males and 49 for females in the 1950s to 68 for males and 72 for females in 1994 (United Nations, 1989; Institute for Population, 1994a).

Even though the overall health status of the Thai people has improved, the rising number of people with AIDS and HIV infection has limited the availability of health care resources. A Thai Study Group (1991) consisting of local and international experts on

AIDS has used mathematical models to predict the future number of AIDS cases in Thailand as the first time. Depending on an assumption that the prevalence of HIV infection at that time continued, the situations of AIDS and HIV infection by the year 2000 in Thailand would be 3 to 4 million cumulative HIV-infected population; 140,000 to 180,000 AIDS cases until the year 2000; 125,000 to 160,000 AIDS deaths until the year 2000; infections of females would outnumber those of males by mid-1995 [3]; about 30 per cent of the future deaths would be caused by AIDS; population would be reduced from 64.8 million to 63.5 million; and the aggregate cost would be US$1.8 to 2.2 billion. However, there were major problems with these projections from lack of reliable data sources at that time.

New HIV projection figures have been available over a year after evaluating existing data sources and taking attention of the current situation of HIV intervention. The national AIDS prevention control efforts have gained success over the past ten years in reducing the total number of Thai men in purchasing sexual services. It was estimated that the percentage of men between the ages of 15 to 49 purchasing sexual services in the last year had dropped from 22 per cent in 1990 to 10 per cent in 1994. The frequency of condom use by men visiting female sex workers had doubled to 60 per cent from 1990 to 1994. In addition, the rate of sexually transmitted diseases infection had declined from 4.5 cases per 1,000 population in 1990 to 1.6 cases per 1,000 population in 1994. These changing risk behaviours in the Thai population which transmit HIV have affected the current and future populations of persons infected with HIV and persons with AIDS. The total number of persons newly infected with HIV each year has started to decrease and the percentage of women among the newly persons infected each year has increased (NESDB Working Group on HIV/AIDS Projection, 1994: i-ii). The cumulative HIV infections was re-estimated at different scenarios ranging from about 887,535 to 930,113 cases in 1995 (NESDB Working Group on HIV/AIDS Projection, 1994: 12).

With a rising number of HIV cases the effects of AIDS on the Thai economy continue to come directly from the rising costs of activities such as those for treatment and caring, education and prevention, training, surveillance and research. In addition, the indirect effect of AIDS in Thailand in the near future will be substantial as shown in Figure 1.2.

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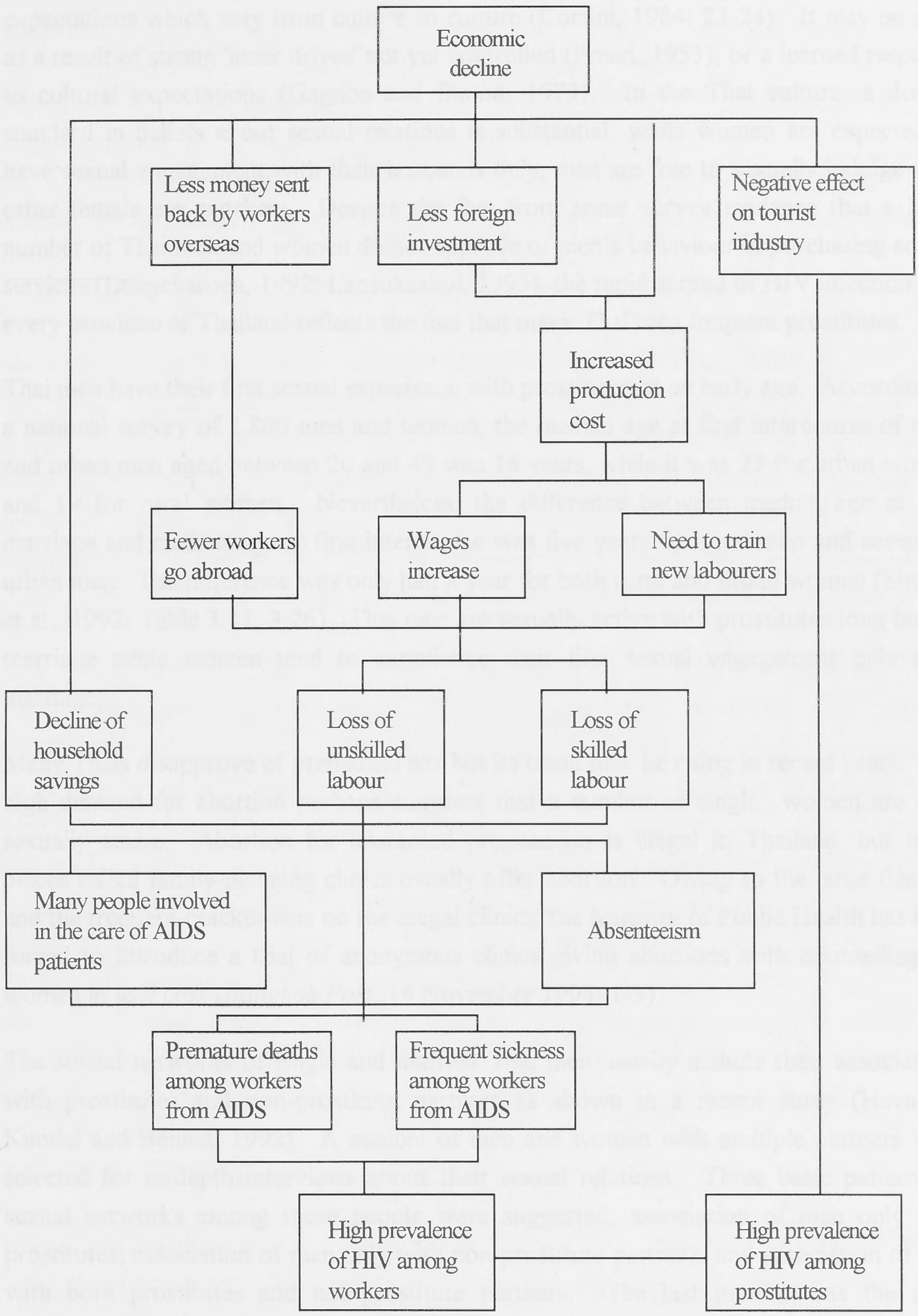
3. Contrary to this prediction, the infections of females did not outnumber those of males by mid-1995 (see Chapter 2 for detail); the extensive educational campaign about AIDS probably led to this change.

Figure 1.2 The indirect economic effect of AIDS in Thailand by the year 2000



Note: This figure is taken from Brinkman (1992: figure 9). The information used to draw this problem tree is from Viravaidya et al. (1991).

1.3 PROSTITUTE PATRONAGE BY THAI MEN

Sexual behaviour may be seen as a social act regulated by strong cultural norms and expectations which vary from culture to culture (Corsini, 1984: 23-24). It may be seen as a result of strong 'inner drives' not yet controlled (Freud, 1953), or a learned response to cultural expectations (Gagnon and Simon, 1973). In the Thai culture, a double standard in beliefs about sexual relations is substantial: while women are expected to have sexual engagement with their husbands only, men are free to sexually indulge with other female sex workers. Despite the fact from some survey evidence that a large number of Thai men and women do not approve of men's behaviour in purchasing sexual services (Longcharoen, 1992: Laosuksakul, 1995), the rapid spread of HIV infection into every province of Thailand reflects the fact that many Thai men frequent prostitutes.

Thai men have their first sexual experience with prostitutes at an early age. According to a national survey of 2,800 men and women, the median age at first intercourse of rural and urban men aged between 20 and 49 was 18 years, while it was 23 for urban women and 19 for rural women. Nevertheless, the difference between median age at first marriage and median age at first intercourse was five years for rural men and seven for urban men. The difference was only half a year for both rural and urban women (Sittitrai et al., 1992: Table 3.11, 3.26). Thai men are sexually active with prostitutes long before marriage while women tend to experience their first sexual engagement only after marriage.

Many Thais disapprove of premarital sex but its trend may be rising in recent years. The high demand for abortion perhaps suggests that a number of single women are now sexually active. Abortion for unwanted pregnancies is illegal in Thailand, but many places called family-planning clinics usually offer abortion. Owing to the large demand and the frequent crackdowns on the illegal clinics, the Ministry of Public Health has been forced to introduce a trial of anonymous clinics giving abortions with counselling for women at low cost (*Bangkok Post*, 14 November 1994: 1-3).

The sexual networks of single and married Thai men usually include their associations with prostitutes and non-prostitute partners as shown in a recent study (Havanon, Knodel and Bennet, 1992). A number of men and women with multiple partners were selected for in-depth interviews about their sexual relations. Three basic patterns of sexual networks among these people were suggested: association of men only with prostitutes; association of men only with non-prostitute partners; and association of men with both prostitutes and non-prostitute partners. The last pattern was the most common among the three. Some men did not use condoms with prostitutes regularly; they also never used condoms with their non-prostitute partners. Those who usually used condoms with prostitutes sometimes or always used condoms with their non-prostitute partners. However, none of these men used condoms with wives even though they sometimes had casual sex with prostitutes without condom use.

Prostitution is not a new phenomenon in Thai society (see Bamber, Hewison and Underwood, 1994). It was previously legalised during the period 1908-1960. Sexually transmitted diseases were initially prevalent among affluent Thai men followed by a later spread among men in the lower classes. Prostitution was outlawed in Thailand in 1960 under pressure from the United Nations. Nevertheless, in 1966 massage parlours or an indirect form of prostitution were legalised (Brinkman, 1992:6). Although prostitution remains illegal, the number of prostitutes in Thailand is believed to be very large, reported at about 150,000 to 300,000 by enumeration (Sittitrai, 1991) and analytical methods (Boonchalaksi and Guest, 1994:32). Many of them are known to be young women from the Upper-North region.

There are many forms of prostitution in Thailand. The Ministry of Public Health has classified at least 18 categories of prostitution in Thailand including nightclubs, beer bars, go-go bars, discotheques, restaurants, cafes, cocktail lounges, pubs, tea houses, massage parlours, traditional massage, hotels, brothels, call girls, coffee shops, beauty salons, barber shops, and mobile discotheques. They are generally classified into direct and indirect prostitution. Brothels are the common form of direct prostitution. A direct prostitute serves between three and nine clients a night on average (Weniger et al. 1991: S75). Many men visit brothels one to three times a month (Rojanapithayakorn, 1988). The cost of sex at brothels is about 50 to 200 baht (A$3-10) which is below or about the minimum wage for workers in Thailand. Therefore, casual sex at brothels is affordable for the lowest-paid workers such as construction and industrial workers, truck drivers, and sailors working on fishing vessels. Students and military conscripts are also known to be regular customers of brothel-based prostitutes. The common form of indirect prostitution is the massage parlours which businessmen and those with higher incomes can afford to visit. The massage parlours are usually well established with hundreds of masseuses in some places. A masseuse usually takes a few clients a night, but she earns more money than those working in direct prostitution. All prostitutes are required to have a free weekly medical checkup at the government sexually transmitted diseases clinics. However, many indirect prostitutes like masseuses have a medical checkup provided by the health professionals at their workplaces. Others may not be medically checked at all as they claim they are not prostitutes.

1.4 RESEARCH QUESTIONS

The sexual relations of the Thai people consist of three parties: men, non-prostitute women and prostitutes. This study is seeking answers to the following questions.

1. How do young people in the Chiang Mai villages form a relationship with the opposite sex? What is there in the culture of Northern Thailand which prevents people from having premarital sex and makes many single men pay for sex? What part does prostitution play in partner relations before marriage? What are the

patterns of partner formation among those living in the rural area? Is it difficult for them to form a relationship?

2. What is there about Northern Thailand that may lead to strength or weakness of marriage? To what extent do Northern women influence their husbands or boyfriends towards prostitution? How much do wives know or suspect about their husbands' extramarital sexual activities and how much do they try to stop them?

3. What is there about Northern Thai society that encourages young women to go into prostitution, and some men to go to them as their clients? What really happens to these women afterwards?

4. How many men have ever had sex with prostitutes? What proportion of them have prostitutes as their first sex partners? At what age do women and men experience their first sex? Do married men continue casual sex with prostitutes after marriage? If they do, are the reasons for casual sex with prostitutes before marriage different from those after marriage?

5. How do people perceive sexuality? What do they believe about AIDS and HIV infection, and how do these beliefs lead to changes in their sexual behaviour? Do wives sometimes refuse to have sexual relations with husbands? If they do, what are the reasons and consequences of their refusal?

6. How does the emergence of the AIDS epidemic in the area lead to changes in sexual behaviour of those living in the rural area? How do people in the villages respond to the spread of AIDS?

1.5 OBJECTIVES OF THE STUDY

1. To explore the socio-cultural factors which influence the partner formation of men and women in Chiang Mai villages.
2. To explore the association of men with prostitutes.
3. To detect the prevalence of men's casual sex with prostitutes and their non-prostitute partners over their lifetime and in recent years.
4. To examine the people's responses about the emergence of AIDS epidemic in the areas.

1.6 RATIONALE FOR THE STUDY

The study of sexual behaviour is new in Thailand. No in-depth study on sexual behaviour was conducted in the context of Thai culture until the rise of the AIDS epidemic a decade ago. The Upper-North region has many distinctive characteristics which make it different from other regions of Thailand. These characteristics may be

summarised as: highest fertility decline, especially in Chiang Mai province; high proportion of non-married men and women; female-dominated migration in employment; high number of prostitutes of both sexes; and high prevalence of people with AIDS and HIV. Although each of these characteristics has been documented and investigated in detail in many studies, none has attempted to link these characteristics of the Upper-North region. This study attempts this task by taking Chiang Mai as a study area. It aims to take the above factors into account for explanations about the spread of AIDS in the Upper-North region. The focus is limited to the village level as it is hoped that some traditional beliefs of the Upper-North people may still remain. It is hoped that the exploration of socio-cultural factors by focusing on people's sexual relations may enable us to understand the development of AIDS in this region.

1.7 ORGANISATION OF THE THESIS

This thesis contains nine chapters. Chapters 1 to 4 give background information and methods of data collection. Chapters 5 to 8 give study results followed by a concluding chapter. The literature review forms part of every chapter which has related topics.

Chapter 1 gives background information about Chiang Mai and the AIDS epidemic in the areas. The recent changes in major socio-economic factors in Thailand are explored. The rationale for the study is discussed. Research questions and objectives of the study are outlined. **Chapter 2** is the literature review giving a summary of the AIDS epidemic by year of events. The current situation of the AIDS epidemic in Thailand is also discussed. **Chapter 3** outlines the methods used for data collection. The characteristics of the study sites are described. **Chapter 4** discusses the quality of data and gives the survey response rate. The socio-economic characteristics of the survey respondents are explored. **Chapter 5** focuses on the socio-cultural factors which influence the partner formation of people in the region. It begins with a literature review about the traditions of northern courtship in the past. Factors leading to changes in courtship behaviour are discussed. The development of prostitution in Chiang Mai is explored. The socio-economic characteristics of the couples before marriage are compared. The marriage squeeze is calculated using data from the 1960 to 1990 censuses to support the claim that there is a surplus of bachelors in the rural areas of Chiang Mai. **Chapter 6** explores the prevalence of casual sex between men and prostitutes and non-prostitute partners before and after marriage. The lifetable age at first intercourse and age at first marriage are calculated for both sexes. Reasons for single and married men to pay for sex are explored. Sexual engagement within marriage is given attention to explain why some married men still pay for sex with prostitutes after they are married. Coital frequency, sexual abstinence, and difficulties of sexual engagement of married people are examined. **Chapter** 7 explores people's beliefs about sexuality. The beliefs about the effects of contraception on sexuality are explored. Some types of male and female sexual practices such as penile pearls, circumcision, and vaginal cleansing are reviewed. **Chapter 8**

details how people in the villages respond to the emergence of AIDS in the areas. Casual sex between men and prostitutes in recent years is explored. The perception of risk of getting AIDS is discussed. **Chapter 9** outlines the lessons learnt and summarises the research findings. Implications of the research are included.

CHAPTER 2

The AIDS Epidemic in Thailand

This chapter provides background to the subsequent chapters of this thesis. It summarises the AIDS epidemic by year of events. The focus of this review is on the development of the AIDS epidemic in Thailand. It shows how the government and the people responded to the spread of AIDS from the early years. The current situation of AIDS in Thailand is given.

2.1 AIDS EPIDEMIC BY YEAR OF EVENTS

The detection of people with AIDS among networks of homosexual men marks the initial recognition of AIDS in Thailand. However, the outbreak of HIV infection in Thailand occurred first among injecting drug users followed by continuous waves of transmission from female prostitutes and their clients. The wives and girlfriends of men who patronised prostitutes were the next to be widely infected with HIV and ultimately the epidemic affected the children born to infected parents (Weniger et al., 1991; Brinkman, 1992; Wongkhomthong et al., 1995). The high awareness of AIDS among the general public in recent years has led to various responses as well as behaviour changes. The following review begins in the year when AIDS first attracted medical interest in the United States followed by the AIDS situation in Thailand.

1981 AIDS emerges this year with reports of the clustering of rare diseases like Kaposi 's sarcoma and pneumocystis carinii pneumonia, as well as unexplained persistent lymphadenopathy found among young, previously healthy, homosexual men in New York and California. The clinical investigators found that, with no history of immuno-suppressive therapy, these men had a common immunological symptom resulting from a significant loss of 'T-helper' cells (National Institutes of Health; 1995).

1983 The role of retroviruses in causing AIDS is reported by two groups simultaneously. The same virus was given different names: 'lymphadenopathy-associated virus'(LAV) by a team of French researchers led by Dr. Montagnier and 'human T-cell leukemia virus type III' (HTLV-III) by a team of American researchers led by Dr. Gallo (Barre-Sinoussi et al., 1983; Gallo et al., 1984; Phanuphak et al., 1985). In this year the first AIDS cases among Africans are reported (Quinn et al., 1986). However, serological data suggest the possibility that the presence of HIV infection in Zaire may have dated back to 1959 (Nahmias et al., 1986). A blood sample tested in connection with an Ebola virus outbreak in Zaire in 1976 has been found to be HIV-infected (Getchell et al., 1987).

1984 AIDS arises in Thailand this year for the first time. The first patient was a homosexual man who returned home for additional care after being hospitalised for

AIDS treatment in the United States (Phanuphak et al., 1985; Limsuwan et al., 1986; Wongkhomthong et al., 1995).

1985 A few more AIDS cases are reported in Thailand and all are found to be associated with homosexual or bisexual behaviour. Because of the lack of diagnostic facilities at this time, a case definition of AIDS is based on the presence of various clinical symptoms associated with immune-deficiency. Serum of patients with AIDS-like symptoms is sent for detection of antibodies to the virus to the Centers for Disease Control laboratory in Atlanta (Phanuphak et al., 1985:196-7). The Ministry of Public Health has announced the inclusion of AIDS in the list of notifiable diseases for case finding starting in May. The enzyme-linked immunosorbent assay (ELISA) commercial test kits have subsequently become available for HIV testing in Thailand this year. Hundreds of prostitutes of both sexes, injecting drug users, male STD patients, blood donors and frequent transfusion recipients have been tested for HIV since then. Only a few male prostitutes are found to be HIV positive at this time (Thongcharoen et al., 1989:17-22; Weniger et al., 1991).

1986 The International Committee of Viral Taxonomy renames the HTLV-III and LAV viruses the human immunodeficiency virus or HIV (Coffin et al., 1986; Gallo and Montagnier, 1987). Blood testing for HIV is widely carried out in Thailand beginning this year because the Saudi Arabian Government requires all workers to be certified AIDS-free before going there to work. Among 46,129 cases tested this year, none is found positive (Thongcharoen et al., 1989: 19; Weniger et al., 1991: Table 5). Only a few more HIV-positive cases, restricted to networks of homosexual men and gay bars, are identified by blood tests among high risk groups. The low HIV-prevalence at this time leads many local experts to believe that AIDS is a disease of foreign homosexuals and their Thai contacts, and that Asians probably have an immunity to the disease (Smith, 1990). In August, the Ministry of Interior includes AIDS in the Immigration Act in an attempt to prevent HIV-infected persons from entering the country and to deport infected persons from the country (Thongcharoen et al., 1989:17). The Western Blot confirmatory test has become available in a few hospitals by mid-year (Thongcharoen et al., 1989:22).

1987 The laboratory service for the HIV test has been expanded dramatically, largely because of the demand for blood tests among many workers seeking employment overseas. More than 30 laboratories are now available for the HIV test in major cities (Weniger et al., 1991: Table 5; Thongcharoen et al., 1989:23). The first case of transfusion-associated AIDS was disclosed in April.[1] Three months later the blood bank at Siriraj hospital has established facilities to screen all units of blood. By October the National Blood Centre has started HIV testing in all units of blood, which has become

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1. With the support of Mr. Mechai Viravaidya, head of the Population and Community Development Association. This AIDS patient is the first person identified to the public. His presentation marks the initial efforts to raise AIDS awareness among the general public in Thailand.

compulsory nationwide in 1989 (Thongcharoen et al., 1989: 23; Chiewsilp et al., 1993; Isarangura et al., 1993).

Meanwhile, this year is 'Visit Thailand Year' promoting the fast-growing tourist industry. Although some non-government agencies have begun educational campaigns among sex workers, the activities are severely restricted at this time by the government officials who believe that publicity about AIDS will affect tourism. Little is achieved in educating the general population. By the end of this year, nearly 200,000 people from selected groups have had HIV blood tests but fewer than 200 persons are found positive. The HIV prevalence of selected high-risk groups is lower than one per cent (Smith, 1990; Weniger et al., 1991; Cohen, 1994).

1988 - the first explosion of HIV infection among injecting drug users. The HIV testing laboratory service has expanded with more than 63 laboratories offering the test throughout the country. All provincial general hospitals are equipped with the necessary laboratory facilities to perform the HIV test by October (Thongcharoen et al., 1989: 23). The first wave of HIV infection takes place this year. HIV prevalence among thousands of injecting drug users in Bangkok rises sharply from 1 to over 40 per cent within one year representing more than 1,000 HIV infected cases (Weniger et al., 1991: Figure 1, Table 2). The sudden increase is believed to result from the release of many prisoners in the previous year (Tanprasertsuk and Pinyothammakorn, 1991:159; Weniger et al., 1991: S81).[2] The outbreak of high HIV prevalence had led some major hospitals to set up a protocol for universal precautions to prevent the spread of the virus. However, the general public is not yet well informed about the outbreak of the epidemic (Boonyeun, 1995).

1989 - the second wave of HIV infection among brothel-based prostitutes. The National Sentinel Surveillance for HIV infection is first introduced in June this year. It is proposed to perform HIV blood tests of about 100 persons belonging to selected risk groups in June and December every year to monitor the spread of the epidemic in each province. The high-risk groups include injecting drug users, direct and indirect female prostitutes, male prostitutes, male prisoners, male patients at STD clinics, blood donors, and women attending antenatal care clinics.[3] The first HIV surveillance in June 1989 covers 14 provinces, the second in December 1989 covers 31 provinces and the third in June 1990 covers the whole country (Tanprasertsuk and Pinyothammakorn, 1991: 146-7). The HIV infection rates among direct prostitutes are unexpectedly high in a few

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2. In 1987 there was a larger than usual number of annual pardons of prisoners on 5 December, the King's birthday. This may have started a chain reaction of HIV spread among injecting drug users in the community as it is known that many prisoners were injecting drug users who tend to share needles.
3. Male prostitutes and male prisoners were later dropped from the HIV surveillance without clear explanation. All subjects being tested for HIV are supposed to be under voluntary confidential testing except pregnant women and male STD patients who receive unlinked anonymous testing, which means that they would not be informed about the test (Tanprasertsuk and Pinyothammakorn, 1991: 159). However, in practice many people are being tested for HIV without their consent and many of them may be told if they are HIV infected (Hongwiwat et al., 1993a, b).

Upper-North provinces. For instance, more than 40 per cent of brothel-based prostitutes in Chiang Mai and Chiang Rai are HIV-positive (US Bureau of the Census, 1995). This prevalence is much higher than the average national rate which is about three per cent among direct prostitutes and none among indirect prostitutes (Division of Epidemiology, 1993).

The Ministry of Public Health attempts to control the spread of AIDS by restricting the networks of people with AIDS. Whenever detected, people with AIDS symptoms or those found to be HIV-infected are sent back to their home province for a follow-up to monitor the progress of the infection by the local health authorities (Thongcharoen et al., 1989: 24). However, the lack of knowledge about the epidemic and the lack of specific government policy on HIV prevention at this time has led many people with HIV, most of whom are prostitutes of both sexes, to resume working again as prostitutes in their home provinces (see case report number 6 in Appendix D). It is not known how many HIV infected prostitutes and injecting drug users are sent back to their provinces under this policy.[4] Return of prostitutes may be one of many factors in HIV spread in the North, however no real evidence exists to support for this being a major component of the spread of HIV/AIDS in the North.

With full awareness that many Thai men patronise prostitutes, the Ministry of Public Health starts the extensive HIV control and educational programs aiming to raise AIDS awareness and to promote 100 per cent condom use campaign beginning this year. Free condoms are distributed to prostitutes who come for routine check-ups at the government STD clinics, and also the brothel owners are approached for their co-operation to promote condom use. The educational campaigns strongly emphasise that clients of prostitutes should always use condoms (Boonyeun, 1995)

1990 - the third wave of HIV infection among clients of prostitutes. Heterosexual contact has apparently become the significant mode of HIV transmission in Thailand. The number of men who patronise prostitutes and are found to be HIV-infected is increasing. According to the National Sentinel Surveillance, the HIV prevalence of men seeking treatments at the STD clinics rose from zero in June 1989 to 4.4 per cent in December the same year. However, the infection rate is consistently highest among those coming from the Upper-North region. Between 10 and 20 per cent of men attending STD clinics in Chiang Mai are HIV infected (Division of Epidemiology, 1993). In another serosurvey, the HIV seroprevalence among 1,161 villagers selected from five semi-rural villages of Chiang Mai is 3.3 per cent for men and 0.5 per cent for women. The annual incidence of HIV infection among those older than 14 years is 3.2 per cent for men and 0.9 per cent for women (Nelson et al., 1994). About 26 million condoms

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4. Although the HIV/AIDS surveillance database is available to tell how many HIV blood tests are performed and how many people have been found to be HIV infected (US Bureau of Census 1995), it cannot be concluded how many Thais have HIV infection because there is no effective way to find out about the repetition of the tests.. For prostitutes, they have a high turnover rate and tehy change workplace often which makes it difficult to detect how many of them are newly infected.

are distributed without charge to prostitutes nationwide this year and the public health officials have begun to monitor condom use among prostitutes. It is claimed that the condom use rate at this time is 50 to 60 per cent (Sittitrai, 1991: 261; Tanprasertsuk and Pinyothammakorn, 1991: 157).

1991 The National Conference on AIDS has started annually beginning this year. From the first conference, it is reported that there are 94 people with AIDS, 243 with the AIDS Related Complex (ARC) and 27,038 with HIV infection reported up to February (Tanprasertsuk and Pinyothammakorn, 1991: Table 2). The discrimination against people with AIDS and their families has become apparent as the number of people with AIDS symptoms increases. The extensive HIV case finding without proper counselling has caused many problems. Those found to be HIV infected without any AIDS symptoms are rejected from the society. Some commit suicide. The others are angry and attempt to spread the virus by having casual sex with many partners without condom use (Hongwiwat et al., 1994a,b). With full awareness of these emerging problems, the Ministry of Public Health stops the earlier policy of extensive case finding of people with AIDS/HIV in September this year. The current policy is to try to provide the HIV blood test only to those who need it; to preserve individual rights, anonymous clinics with counselling are introduced for those who wish to know about their risk of getting HIV. The number of people with HIV is also dropped from the report of the National Sentinel Surveillance. Only the number of people with AIDS and the prevalence of HIV infection among selected risk groups taken from every province is now reported in the National Sentinel Surveillance.

Although the reports of the number of people with HIV have been discontinued, the numbers of people with HIV are already found to be very high in some Upper-North provinces. For instance, the cumulative number of HIV-infected people last reported in Chiang Rai for this year alone is 6,380 (Centre for Communicable Diseases Control of Chiang Rai, 1992). Despite the forceful campaigns to promote 100 per cent condom use, at this time condom use is still low. For instance, only 61.5 per cent of 2,417 men aged 19 to 23 years recruited to the Army report condom use at last sex with prostitutes (Nelson et al., 1993).

Twice-yearly HIV serosurveys among army recruits are conducted for a trial period starting in November 1991. Three per cent of about 30,000 young men aged 21 years throughout the country are found to be HIV infected in 1991, but the HIV prevalence of those coming from the Upper-North region is five times greater (Sirisopana et al., 1992; Nopekesorn et al., 1993)[5]. This is in accord with many serosurveys suggesting that a

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5. It was claimed that the HIV serosurveys obtained from the military conscripts are highly reliable because all conscripts would be tested for HIV without selection (Brown and Sittitrai, 1993). However, besides compulsory military conscription, any young men aged 21 could also voluntarily enlist regardless of their HIV serostatus (see case report number 5 and 6 in Appendix C). Therefore, the HIV prevalence among the conscripts could be biased if conscription becomes a pull factor for young men with HIV to volunteer for military services. The

large number of HIV-infected prostitutes also come from this region (US Bureau of Census, 1995). This indicates that HIV has started to be transmitted from infected prostitutes to their male clients.

Table 2.1 compares the regional distribution of cumulative numbers of people with AIDS, ARC and HIV infection reported in 1991 and the cumulative number of people with AIDS and ARC reported in 1993. The prevalence in 1991 was highest in the Central region and Bangkok followed by the Northern region. However, the prevalence of infected people became highest in the Northern region two years later. The shift in the regional distribution of infected people probably reflects the government's policy of sending back the people with AIDS and HIV to their home provinces as started in 1989. Many prostitutes of both sexes are known to come from the Upper-North region, and therefore the HIV prevalence is expected to be very high in this region.

Table 2.1 Comparison of regional distribution of people with AIDS, ARC and HIV infection reported in 1991 and of people with AIDS and ARC reported in 1993

Region	Number of people with AIDS, ARC, and HIV infection [a]		Percentage distribution of the prevalence		Prevalence rate per 100,000 population [b]	
	1991	1993	1991	1993	1991	1993
Central	8,237	1,170	30	16	68	10
Bangkok	7,601	1,115	28	15	129	19
North	6,215	4,145	23	56	59	39
South	2,977	333	11	4	43	5
Northeast	2,345	691	8	9	12	4
Total	27,375	7,454	100	100	50	14

a In 1993, people with HIV infection were excluded from the reports as explained earlier.
b Number of population by region was taken from the 1990 Population Census (National Statistics Office, 1992: Table 1)

Sources: Tanprasertsuk and Pinyothammakorn, 1991: Figure 1: Division of Epidemiology, 1993.

1992 About one per cent of pregnant women coming for prenatal care at the government clinics throughout the country are found to be HIV infected suggesting that the epidemic has reached the low-risk population (Division of Epidemiology, 1993). Infected men have started to transmit the virus to their wives and girlfriends. The rising number of people with AIDS creates an urgent need for community and home-based care encouraging people with AIDS to be looked after by their family and community (Wongkhomthong et al., 1995).

benefits of joining the military services for the people with HIV are at least free medical care, free meals and regular pay.

The number of child prostitutes or those aged below 18 is believed to be rising in recent years, as some men believe that sexual relations with virgins or very young women will minimise their risk of getting AIDS. Hence, the government has launched a law demanding severe punishment for the managers of child prostitutes. Parents who allow their children aged below 18 to be prostitutes are also punished (Institute for Population and Social Research, 1994b: 153).

1993 Homes for AIDS orphans are introduced in Chiang Mai suggesting an urgent need to support children whose parents have died of AIDS (Vithayasai and Vithayasai, 1994). From screening for HIV-antibodies among blood donors in Chiang Mai, seropositivity increased from 0.84 per cent in 1988 to 4.04 per cent in 1991. However, the infection rate was found to be highest among paid professional donors. After discontinuation of the use of paid donors, the HIV prevalence among blood donors in Chiang Mai dropped to 3.3 per cent which may reflect the level of HIV infection among the general population of Chiang Mai at that time (Mundee et al., 1995).

This year the numbers of people with AIDS/HIV in Thailand are re-estimated.[6] Data sources include the HIV seroprevalence among all military conscripts, selected pregnant women attending the government antenatal care clinics, and cumulative AIDS cases reported throughout the country. It is found that between 560,000 and 700,000 people were HIV infected in mid-1992 and between 660,000 and 825,000 people are HIV infected in mid-1993. This represents an incidence of 10,000 new HIV infections per month. Infections of men outnumber infections of women but the male to female ratio of infection has declined from 9.2 in 1991 to 2.5 in 1993. Infections in the North account for at least one-third of the total infections of the country (Brown and Sittitrai, 1993).

1994 After evaluating existing data sources and the current situation, the NESDB Working Group on HIV/AIDS Projection (1994: ii-iii) presents an executive summary projections of HIV/AIDS in Thailand suggesting the success of the national AIDS prevention and control efforts. It is suggested that the total number of persons newly infected with HIV each year has started to decrease since 1991. The majority of persons losing their lives to AIDS are between the ages of 20 and 39. About 0.6 million persons in this age range or 75 per cent of all persons die of AIDS will have died by the year 2005. The projections also indicate that the ratio or men to women newly infected changed from 97 to 3 in 1988 to 46 to 54 in 1993 and will be about 60 to 40 by the year 2005.

Up to the end of October this year, 13,246 people with AIDS come for medical treatment to hospitals under the Ministry of Public Health. Of this figure, 3,902 die: 66 per cent of the dead are heterosexuals, 10 per cent are homosexual and the rest are unknown. The highest death rate is reported in Chiang Rai with 660 cases, followed by Chiang Mai with 583 and Bangkok with 351 cases (*Bangkok Post*, 17 November 1994).

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6. The first estimation was carried out by the Thai Working Group in 1991. The results are given in Chapter 1.

A random survey of 200 people in ten villages of Maehongson province shows that 18.5 per cent of the people are HIV positive (*Bangkok Post*, 26 February 1995). Twenty-three people claim that they contracted HIV through blood transfusion (*Bangkok Post*, 1 December 1994). The first of at least four AIDS vaccine trials is conducted in Thailand this year (*Bangkok Post*, 31 December 1994).

1995 The cumulative number of people with AIDS rises to 19,095 cases, compared to only 94 four years ago. One-fourth of these people have died of AIDS (*Bangkok Post*, 2 February 1995). About 6,000 infants have been born with AIDS (Boonyeun, 1995). Some studies claim to detect recent changes in the sexual behaviour of Thai men. For instance, the low incidence of new HIV-infected cases among more than 30,000 Army recruits probably suggests that young men's sexual behaviour is changing (Kitsiripornchai et al., 1995). Some men probably abstain from casual sex with prostitutes, or may have it less often. Others may have casual sex with prostitutes with consistent condom use. However, it is not known how long this changing behaviour will be maintained. In another study, the age at first intercourse of young men, especially university students, has increased because of their fear of contracting AIDS (VanLandingham et al., 1992). A sharp decline in the number of male STD clients at the government clinics is claimed to be the result of the high condom use rate of more than 90 per cent as monitored by the Ministry of Public Health (Hanenberg et al., 1994: Table 2). However, the sharp decline in reported STD cases may have been due to the fact that STD-infected persons probably prefer private treatment in recent years because they know about the link between STD and AIDS. Table 2.2 shows the summary report of the HIV and AIDS cases in Thailand from September 1984 to December 1995. The report is based on the cumulative AIDS cases and the estimated numbers of people with HIV.

Table 2.2 HIV and AIDS cumulative cases reported between September 1984 and December 1995

	HIV infected cases		Cumulative AIDS cases
	New cases	Estimated	
1984	-	-	1
1985	5	-	6
1986	10	-	8
1987	171	-	20
1988	5045	12850[b]	28
1989	10648	86000[b]	129
1990	14842	297000[b]	298
1991	a	499000[b]	837
1992	a	634000[b]	2498
1993	a	708000[b]	7454
1994-1995	a	750000[c]-850000[b]	10673
1995	a	1.4 millions[b]	24595
2000[a]	a		480,000[b]

a Reports of seropositive HIV ceased in September 1991. The cumulative number of HIV cases up to February 1991 was 30,721 (Tanprasertsuk and Pinyothammakorn, 1991; Smith, 1990).

b Figures estimated by Brown (cited by Cohen, 1994).

c Estimated figure reported by Ministry of Public Health, 1995.

Sources: Tanprasertsuk and Pinyothammakorn, 1991; Smith, 1990; Brown and Sittitrai, 1993; *Bangkok Post*, 30 July 1995; Division of Epidemiology, 1993.

2.2 CURRENT AIDS SITUATION

The distribution of people with HIV/AIDS by selected characteristics is described here using the following data sources: the cumulative number of people with AIDS reported up to the present time; the cumulative number of people with HIV reported before the anonymous clinics for HIV tests were introduced in 1991; and the National HIV Sentinel Surveillance which has reported HIV prevalence among selected high-risk groups since 1989.

All these data sources have their own weaknesses for various reasons. The cumulative number of people with AIDS tends to be under-reported. For instance, some people may never seek care from the hospital for AIDS. Even if they do, some doctors may not want to diagnose a person with AIDS because of the stigma attached to it, or some doctors may not recognise cases of HIV infection. Furthermore, a number of people with HIV infection may die of other diseases, not AIDS. For the second data source, there is no standard criterion for selecting people for the HIV test. Therefore, the prevalence of people with HIV is represented only by the people with high-risk behaviour, such as prostitutes and drug users; the prevalence among the low-risk groups is not known. Lastly, for the third data source, the National Sentinel Surveillance may be less reliable because the sample sizes are small and not representative. Only about 100 cases of people from selected groups are tested for HIV with no standard criterion of sample selection. However, this surveillance is the only report taken regularly from

selected high-risk groups in every province. Therefore, trends of the infection and the general situations of the epidemic can be monitored by this surveillance.

2.2.1 By Region

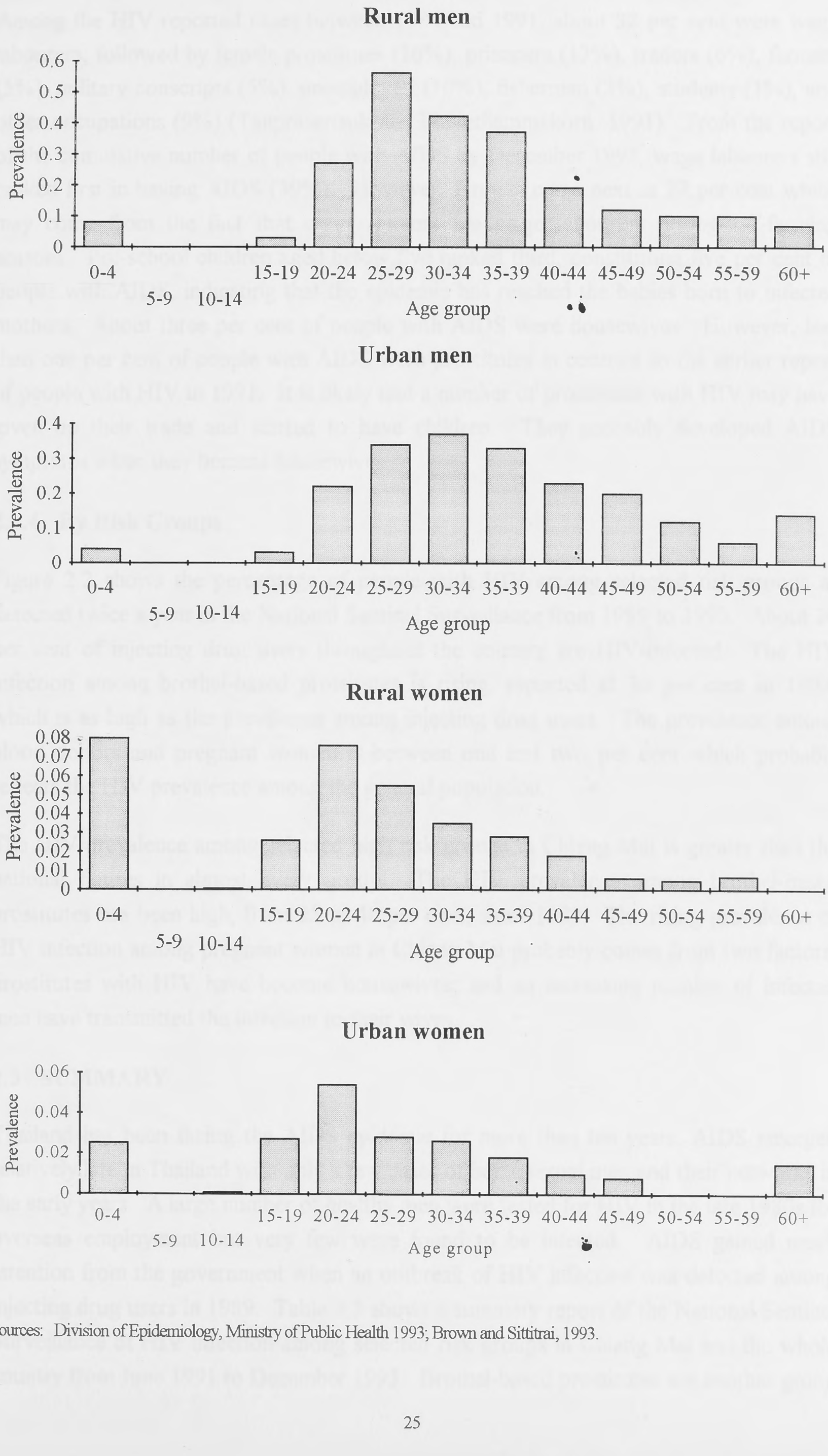
The prevalence of AIDS/HIV has been consistently highest in the Upper-North provinces as discussed previously in Chapter 1.

2.2.2 By Age, Sex and Place of Residence

Figure 2.1 shows the distribution of cumulative AIDS cases per 1,000 population. The total number to December 1993 was about 6,300 men and 1,100 women. About 80 per cent of them were from the rural areas. Men with AIDS were found in most age groups with about 70 per cent in age group 20 to 39. The highest prevalence of AIDS is in age group 25 to 29 for rural men, age group 30 to 34 for urban men, and age group 20 to 24 for women in both rural and urban areas.

Among 30,721 cumulative cases of people recorded as having HIV from 1984 to February 1991, the male to female ratio of infection declined from 17 in 1986 to 2 in 1990. Nevertheless, the increased number of women with HIV during that period was the result of nationwide compulsory HIV blood tests among prostitutes. More than 80 per cent of women found to have HIV at that time were prostitutes (Tanprasertsuk and Pinyothammakorn, 1991:139-142).

Figure 2.1 AIDS cases per 1,000 population by place of residence



Sources: Division of Epidemiology, Ministry of Public Health 1993; Brown and Sittitrai, 1993.

2.2.3 By Occupation

Among the HIV reported cases between 1984 and 1991, about 32 per cent were wage labourers, followed by female prostitutes (16%), prisoners (13%), traders (6%), farmers (5%), military conscripts (5%), unemployed (10%), fisherman (3%), students (1%), and other occupations (9%) (Tanprasertsuk and Pinyothammakorn, 1991). From the report of the cumulative number of people with AIDS by December 1993, wage labourers still ranked first in having AIDS (39%). However, farmers came next at 27 per cent which may come from the fact that many farmers are wage labourers during off-farming seasons. Pre-school children aged below five ranked third, constituting five per cent of people with AIDS, indicating that the epidemic has reached the babies born to infected mothers. About three per cent of people with AIDS were housewives. However, less than one per cent of people with AIDS were prostitutes in contrast to the earlier report of people with HIV in 1991. It is likely that a number of prostitutes with HIV may have given up their trade and started to have children. They probably developed AIDS symptoms when they became housewives.

2.2.4 By Risk Groups

Figure 2.2 shows the percentage of people with HIV among selected risk groups as detected twice a year in the National Sentinel Surveillance from 1989 to 1993. About 30 per cent of injecting drug users throughout the country are HIV-infected. The HIV infection among brothel-based prostitutes is rising, reported at 30 per cent in 1993, which is as high as the prevalence among injecting drug users. The prevalence among blood donors and pregnant women is between one and two per cent which probably reflects the HIV prevalence among the general population.

The HIV prevalence among selected high risk groups in Chiang Mai is greater than the national figures in almost every group. The HIV prevalence among brothel-based prostitutes has been high, from 25 to 40 per cent, since 1989. The rising prevalence of HIV infection among pregnant women in Chiang Mai probably comes from two factors: prostitutes with HIV have become housewives; and an increasing number of infected men have transmitted the infection to their wives.

2.3 SUMMARY

Thailand has been facing the AIDS epidemic for more than ten years. AIDS emerged relatively late in Thailand with only a few cases of homosexual men and their networks in the early years. A large number of healthy men were tested for HIV in the late 1980s for overseas employment but very few were found to be infected. AIDS gained much attention from the government when an outbreak of HIV infection was detected among injecting drug users in 1989. Table 2.3 shows a summary report of the National Sentinel Surveillance of HIV infection among selected risk groups in Chiang Mai and the whole country from June 1991 to December 1993. Brothel-based prostitutes are another group

found to be infected with HIV with increasing prevalence. The provincial HIV infection rates may reflect where the prostitutes come from rather than where they became infected. The strong educational campaigns on AIDS as adopted in recent years has been successful in raising AIDS awareness among the general public, the estimated number of Thai people with HIV has been reduced, and condom use is claimed to be at a high rate with consistent usage. However, the use is limited to casual sex between men and prostitutes. The impact of AIDS on Thailand will continue as many people have already been found to be infected with HIV. Furthermore, a number of Thai men continue to have casual sex with prostitutes despite their awareness of the existence of AIDS. Without any cure or vaccine, changes in sexual behaviour seem to be the only effective way to control AIDS in Thailand.

Table 2.3 The National Sentinel Surveillance of HIV infection in selected groups in Chiang Mai and the whole kingdom reported in percentage

Risk groups	June 1989	Dec-1989	June 1990	Dec-1990	June 1991	Dec-1991	June 1992	Dec-1992	June 1993	Dec-1993
THE WHOLE KINGDOM										
Direct prostitutes	3.5	6.3	9.3	12.2	15.2	21.6	23.0	23.9	30.6	29.8
Indirect prostitutes	0.0	1.2	1.2	2.5	4.0	5.4	4.7	6.4	8.6	9.1
Male prostitutes	2.7	2.3	5.3	10.8	7.7	7.4	13.5	10.5	a	a
Males attending STD clinics	0.0	2.0	2.5	4.4	5.0	5.5	5.7	6.0	9.8	8.7
Blood donors	0.3	0.2	0.4	0.4	0.4	0.8	0.8	0.9	1.2	1.1
Pregnant women	0.0	0.0	0.2	0.7	0.9	1.0	1.4	1.4	1.9	1.8
Injecting drug users	39.0	30.1	31.4	30.1	35.1	33.9	38.2	36.4	34.3	33.0
CHIANG MAI										
Direct prostitutes	44.0	42.7	45.6	23.2	39.9	35.4	40.8	53.1	46.4	38.5
Indirect prostitutes	5.0	9.8	5.4	8.9	9.5	12.3	9.0	10.0	10.0	7.5
Male prostitutes	1.7	2.2	17.7	14.0	11.1	15.9	15.3	17.8	a	a
Males attending STD clinics	10.0	17.8	18.0	11.5	22.0	15.5	19.5	21.5	27.0	16.0
Blood donors	3.7	4.5	3.5	4.0	3.1	10.0	4.9	5.2	6.2	3.7
Pregnant women	1.0	0.0	1.9	4.5	4.5	1.5	4.9	5.8	4.9	8.0
Injecting drug users	16.0	60.0	40.0	45.8	42.8	61.0	51.0	60.6	55.0	51.0
Male prisoners [b]	27.0	38.8	40.0	24.1	26.0	38.9	a	a	a	a
Female prisoners [b]	4.0	8.7	10.0	5.4	6.7	12.0	a	a	a	a
Male prisoners, nearly released [b]	34.0	63.8	54.5	52.9	51.5	42.8	a	a	a	a
Female prisoners, nearly released [b]	0.0	20.0	20.0	2.7	20.0	20.0	a	a	a	a

a Data are not available

b Only data for Chiang Mai are available.

Sources: Tanprasertsuk and Pinyothammakorn, 1991; Centre for Communicable Diseases Control of Chiang Mai, December 1993; Division of Epidemiology, Ministry of Public Health, 1993.

CHAPTER 3
Research Methodology

A combination of standard survey techniques with qualitative approaches was used for data collection. Twelve villages of Chiang Mai were selected as study sites. This chapter describes their characteristics and outlines three phases of data collection. The problems that occurred during the fieldwork are discussed.

3.1 EXPLORATION FOR RESEARCH METHODS

Different kinds of studies have contributed knowledge about human sexuality. Although they are from different disciplines, these studies may be divided into four groups based on their similar approaches. The first group of studies utilise qualitative techniques such as individual interviews and group discussions to collect information from subjects of interest. The best known type is the psycho-medical case study focusing on sexual behaviour of an individual that deviates from what is considered to be acceptable or normal. An individual is usually interviewed a number of times to assess the factors which may influence his or her sexual behaviour. However, this kind of study provides knowledge about people with atypical behaviour and is limited to the hospital or clinic environment. In recent years, many studies use interviews or group discussions to collect information from selected numbers of people who share some common characteristics such as men with multiple partners, prostitutes, truckers, and people with AIDS. This type of study provides good knowledge about the sexual sub-culture of people in selected groups. However, little is known about how these people's behaviour differs from that of the general population.

The survey approach is the second type of study that has provided knowledge about sexual behaviour. It usually involves a large sample size with standard questionnaires for data collection. Many socio-demographic and epidemiological studies have used a standard survey to obtain information such as age at first intercourse, number of sex partners, type of sexual practices, frequency of intercourse and condom use. Some recent studies show that a standard survey with appropriate sampling contributes substantial information about human sexuality (see Wellings et al., 1994; Michael et al., 1994). However, the information obtained from this kind of survey is limited since sexual behaviour is likely to be defined as a matter of how often people have intercourse and with how many partners. In other words, the rates of sexual activity are the main result of these studies (Dyson, 1992). Such emphasis was pointed out by Watkins (1993) to be following the tradition in the demographic literature on fertility and proximate determinants. Little attempt has been made to explain why people have intercourse or why people change partners. Information from survey studies is

interpreted within a limited framework of selected variables, therefore some substantial components of sexual behaviour may be overlooked.

Several biases may be easily introduced to a survey study. The lesson learnt from the Kinsey reports in the early years is worth a review. In 1948, Dr. Kinsey, a well-known biologist in the United States, reported the survey results in a book called *Sexual Behavior in the Human Male*, which contained information collected from individual interviews with more than 5,000 men of all ages. This report was initially well-accepted by the public because it was the first time that men could find out from the survey about the sexual behaviour of other men. In 1953, another report on *Sexual Behavior in the Human Female* came out: about 6,000 women of all ages were interviewed. However, the public was much offended by the information given in this report; for instance, it said that nearly half of the women had not been virgins when they married, and 25 per cent of married women engaged in extramarital sex. The report of these unexpected behaviours made many people question how Kinsey recruited the respondents and how the questions were asked. Regardless of the large sample size, the Kinsey reports were found to be biased because there was no standard criterion for sample selection. All respondents volunteered to participate. Thus, the reports did not represent the general population but were likely to be dominated by people with atypical behaviour. The questionnaires also caused doubts because only a limited choice of answers was available (Cochran, 1954; Reinisch and Beasley, 1991).

The anthropological approach is the third kind of study that has shed some light on the subject of sexual behaviour. Anthropologists usually live with people in the communities of interest for a period of time to observe the people's lives and activities; some people call this approach participant observation. A simple survey is usually conducted in the early stage to provide knowledge about the structure of the communities under study. The information is obtained from observation and casual interviews or discussions with people in the areas. Although this type of study requires a long period of participation with the subjects, some recent studies have shown that the participant observation technique can be used successfully to obtain information about people's sexual behaviour in a limited time (see Narumon, 1988; Saweangdee and Isarabhakdi, 1991).

A combination of qualitative and quantitative approaches is the fourth type of study that has been increasingly used since sexual behaviour has become a major subject of study in many countries following the outbreak of AIDS epidemic (see Dyson, 1992). Qualitative approaches such as individual interviews, group discussions and participant observation have been used in supplement to a standard survey. The mixed method provides the researchers with an opportunity to compare responses in more than one approach.

In this study, the mixed method was used for data collection. Individual interviews and group discussions were used in the initial phase to gain knowledge from the people and

also to guide the survey. Participant observation and group discussions were used in the final stage to help interpret the results.

3.2 AREAS OF STUDY

Three districts were selected for the study based on the criteria that the prevalence of HIV infection rate in these districts is high and, to cut transport cost, these villages are close to the city. Sanpathong, Maerim and Sansai were selected out of 19 districts of Chiang Mai province.[1] As shown in Figure 3.1, the cumulative number of people with AIDS obtained from these three districts was more than 25 per cent out of 886 AIDS cases totally reported in Chiang Mai by April 1993 (Communicable Diseases Control of Chiang Mai, 1993).

The selection of villages within the selected districts was not an easy process since distance of the village and willingness of the headmen to participate were major factors to be considered for village selection. The similar selection of villages included in the 1993 Chiang Mai Labour Force Survey was used as a convenient choice as it was hoped that people in the areas would be familiar with the survey procedures.[2] Also, by adopting the selection of this survey, it was hoped that the selected villages would not be clustered in a particular area. Fourteen villages within these three districts were targeted for the survey. The district and the village heads were approached for their co-operation. All except two village heads were willing to participate, and the remaining 12 villages were used for the household survey.

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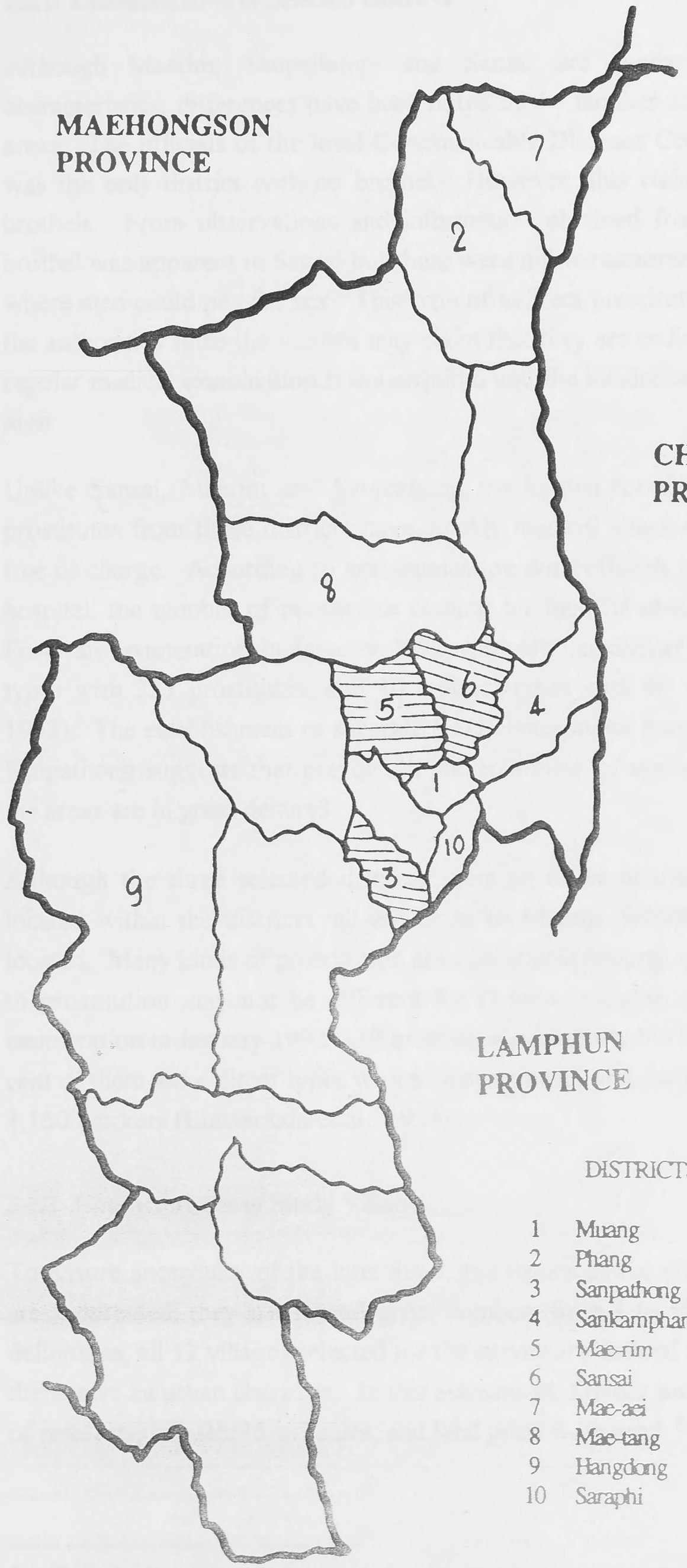
1. Chiang Mai province is administratively divided into 19 districts (amphoe), three sub-districts (king amphoe), 191 communes (tambon), 1,656 villages (moo baan) and one municipal area.
2. This survey was conducted by the National Statistical Office. A total of 83 urban and rural blocks of the whole Chiang Mai province were systematically selected using probabilities proportional to the best available measure of size. Within the three districts selected for my study, 14 rural blocks (villages) were chosen for the 1993 Chiang Mai Labour Force Survey.

Figure 3.1 Ten districts of Chiang Mai with highest cumulative number of people with AIDS and ARC



	DISTRICTS	AIDS/ARC Cases	Per 100,000 population
1	Muang	143	6.6
2	Phang	117	12.8
3	Sanpathong	79	10.9
4	Sankamphang	78	9.4
5	Mae-rim	68	10.1
6	Sansai	51	7.1
7	Mae-aei	50	10.1
8	Mae-tang	47	6.8
9	Hangdong	43	9.4
10	Saraphi	37	5.6

3.2.1 Characteristics of Selected Districts

Although Maerim, Sanpathong, and Sansai are similar in their socio-economic characteristics, differences have been noted in the number and type of brothels in these areas. The officials of the local Communicable Diseases Control suggested that Sansai was the only district with no brothel. However, this claim may refer only to direct brothels. From observations and information obtained from people in the areas, no brothel was apparent in Sansai but there were a few restaurants and entertainment places where men could pay for sex. This type of indirect prostitution cannot be controlled by the authorities since the women may claim that they are ordinary waitresses. Therefore, regular medical examination is not required and the incidence of unprotected sex may be high.

Unlike Sansai, Maerim and Sanpathong are known for their low-cost brothels. The prostitutes from these districts have weekly medical check-ups at the district hospitals free of charge. According to communication with officials and observation at a district hospital, the number of prostitutes coming for medical check-ups is about 20 per day. From an enumeration in January 1992, Sanpathong district had 33 brothels: 23 direct types with 223 prostitutes, and 10 indirect types with 69 workers (Limanonda et al., 1993). The establishment of separate STD clinics in the hospital districts of Maerim and Sanpathong suggests that prevention and treatment of sexually transmitted infections in the areas are in great demand.

Although the three selected districts seem to differ in the availability of prostitution located within the districts, all are close to Muang district where Chiang Mai city is located. Many kinds of prostitution are available in Muang; therefore, the access for men to prostitution may not be different for those coming from these districts. From an enumeration in January 1992, 119 brothels were reported in Muang district: about 40 per cent of them were direct types with 899 prostitutes, and the rest were indirect types with 1,160 workers (Limanonda et al., 1993).

3.2.2 Characteristics of Study Villages

To ensure anonymity of the interviews, the names of the villages selected for the study are suppressed; they are instead given numbers from 1 to 12. According to the official definitions, all 12 villages selected for the survey are defined as rural villages, but three of them have an urban character. In this assessment, factors such as income and occupation of residents, household structure, and land price were used. [3]

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3. Thailand is divided into municipal areas, sanitary districts, and non-municipal areas. Municipal areas are generally urbanised. Sanitary districts are subdivided into urban and rural districts. An urban sanitary district comprises a population of at least 5,000 persons, while rural sanitary districts have a population of less than 5,000 persons. However, population distribution has been divided as those residing in municipal and non-municipal areas only, and administratively rural areas are defined as the

Urban Villages

Three out of the 12 selected villages are large and urbanised with more than 250 households. Their residents have direct access to highways to the city; transport to the city by car from these villages takes about one hour, and many residents commute between their living places in the villages and their workplaces in the city. About 70 per cent of the households are built of concrete; thatched houses are less apparent. There are schools that provide secondary education with about 300 students. All these villages are near district hospitals; there are also some private medical clinics in the vicinity. There are some grocery shops, restaurants, rowhouses and shophouses in the areas, which indicates urban life styles.[4] Only small areas of farmland are in use in these villages. Rice is grown mainly for personal consumption. Although some people still earn their living by growing agricultural products for sale, they tend to make use of other fields outside the villages where the cost of land is cheaper. Over the past ten years, the land prices in the areas surrounding Chiang Mai city have increased, and much farmland has been sold and turned into residential areas for communities. The high cost of land has led to changes in the social structure of the villages. For example, a housing estate appears in one of these urban villages; according to the village heads, the residents of this housing estate tend to have moved in from urban areas.

Rural Villages

The remaining nine villages have a rural character. The size of these villages ranges from 80 to 450 households. Large size of a village does not necessarily mean that the village is urbanised. Thatched houses are more common than in the urbanised villages. Most villages have easy access to highways. While food stalls are available, there are no restaurants within the villages. People of these villages grow rice, tobacco, vegetables, or garlic as their main occupational activity; some earn extra income working for wages outside the villages. The land price in these villages is lower than in the urbanised villages, and the traditional structure of the villages has not been disturbed by any recently arrived people. Only two villages have schools. Limited health care is available, but there are no hospitals.

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areas outside the municipal areas (National Statistical Office 1990). Therefore, all 12 villages which are located outside the municipal areas are defined as rural areas.

4. Rowhouses and shophouses are usually seen in the city centre. A typical characteristic of the shophouse is that the ground floor is used for commercial trading and the upper floor is used as a living place. The peasants usually build their houses on the land given by their parents. The housing estate, however, is a phenomenon of urban life style which has been popular in Thailand in the past 20 years. Estates are built for sale by land developers. A typical house in the housing estate has very little land which is distinctive from a typical house in the rural areas where a larger land space is common. In the past the housing estates were only found in Chiang Mai city, but during the fieldwork it was found that many housing estates have now been built and offered for sale along the highways connecting Muang and the surrounding districts.

3.3 A SUMMARY TIMETABLE OF THE FIELD PROCEDURES

Data were collected from August 1993 to March 1994. The field procedures are summarised as follows.

YEAR	MONTH	ACTIVITIES
1993	August-September	Contact officials at the National Statistical Office and the Communicable Diseases Control Office for selection of the study sites. Survey of the study sites and contact authorities for co-operation.
	August-October	Exploration - conduct in-depth interviews and group discussion.
	October	Recruitment of interviewers. Conduct survey pretest in one village.
	November-mid December	Conduct household survey in 12 villages
1994	January-March	Participant observation and group discussions

3.4 EXPLORATION PHASE

To gain insights into the nature and patterns of sexual behaviour, a group discussion and some individual interviews were conducted with selected men and women between August and October 1993. The purposes were as follows:

1. To evaluate the responses of both sexes to questions about their sexual behaviour.
2. To evaluate how people in the villages respond to the AIDS epidemic.
3. To explore unprecedented issues which were not included in previous studies.
4. To revise previously written questionnaires based on the new information obtained in this phase.

3.4.1 Group Discussion

A group discussion of married men and women was conducted as a test in one of the survey villages. Six men and six women aged between 30 and 50 years were invited through the village head to join an hour of discussion about AIDS and sexual relations. The discussion was recorded for subsequent transcription. It was learnt that despite the mix of sexes in this group discussion, men and women talked openly about their sexual relations. Married men were criticised for their frequent casual sex with prostitutes which subsequently transmitted the HIV infection to their wives. However, men argued that prostitute patronage was common behaviour for Thai men who often paid for sex when they were single. Friends' persuasion and drinking habits were the major factors leading them to pay for sex. They claimed that a good relationship within marriage

would make most married men abstain from casual sex with prostitutes. During the time of the AIDS outbreak, all participants agreed that most men in the village had stopped frequenting to brothels for fear of getting AIDS. Those who still did were likely to be men without wives. Although a group discussion of mixed sexes provided an opportunity for men and women to discuss openly what they thought about each other, it was difficult to control the discussion of mixed sexes. Only individual interviews were used to obtain further information in this phase. More group discussions specific to sexes and marital status were carried out in the last phase of data collection.

3.4.2 In-depth Interviews

A non-randomly selected number of men and women were invited for a personal interview through various channels including personal contacts, government officials, community leaders, and owners of brothels. Informed consent and permission were obtained from them before the interviews, which were conducted in a casual style but privately without note-taking or voice-recording. The life history review framework was used as a guideline to obtain the information for each individual. A description of the interviews was written from memory immediately after the conversation. A total of 39 men and women were interviewed as shown below.

MEN

Five married men with multiple sex partners. One man had AIDS.

Seven single men with multiple sex partners. Two men were HIV-positive and one man had AIDS.

WOMEN

Fifteen female prostitutes, 12 were direct type and three were indirect type.

The wife of an HIV positive man.

Eight married women, half were injecting drug users.

Three single women, two had regular sex partners.

3.4.3 Content of Questionnaires

Both male and female questionnaires were developed; the content of the questionnaires was revised after getting more information from in-depth interviews and group discussion. Further adjustments were made after the survey pretest. As shown in Appendix A, male and female questionnaires comprise eight sections. The first four sections contain similar questions for respondents of both sexes. The questions include socio-economic characteristics of the respondent; marital status and characteristics of spouses for married respondents; relationships with non-paid partners; and source of information and attitudes about sexuality. Questions in the last four sections correspond to a specific sex, and some questions are comparable between the sexes. The questions include sexual norms and practices; relationships with paid partners; sexual health and

sexually transmitted diseases; and perceived risk of getting HIV infection. Most questions were open-ended with some precoded answers and a few scalings.

3.4.4 Training of Interviewers

Three research teams took part in the survey. Each team was composed of three persons including one local facilitator and interviewer of each sex; three men and two women were recruited as interviewers. The researcher acted as an interviewer as well as a field supervisor. The interviewers were recruited from the city through advertising posters one month before the survey to allow sufficient time for training. The requirements for the job were fluency in the northern dialect, and a completed college education; after a pre-selection, 20 applicants were asked to attend a meeting. Each applicant was asked to have a casual interview with another applicant of the same sex about his or her sexual relations; a written description of the interview was required on the following day and it was used to select the interviewers. Training for communication and observation skills was given before the survey pretest. The northern dialect was the main language used for interview.

3.5 HOUSEHOLD SURVEY PHASE

3.5.1 Pretesting and Adjustments

A village in Sansai was selected for a pretest; this village is not included in the actual survey. Households were randomly selected from the village map; in each household, only one woman or one man aged 15-49 was selected for the interview. However, two major problems were encountered during the test: first, there was a respondent from fewer than half of the households despite at least three visits; secondly, it was found that sometimes the procedure aroused the suspicion of other members in the household. Often it was suspected that the person selected for interview was targeted because he or she had AIDS. To avoid such problems in the actual survey, all men and women aged 15-49 in the households of the sample were interviewed.

3.5.2 Selection of Households

The survey aimed at obtaining at least 500 cases of men and women aged 15-49. A systematic random sampling was employed for the selection of households. The village map or the 1992 electoral roll[5] was obtained from the village heads; the electoral roll provided information about the addresses, and names of all persons aged 21 years and older whose names appear in the household registration record. For each village, a list of

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5. In the actual survey, the village map was obtained from only five villages. I feel that the list of households obtained from these maps was highly reliable because they had been recently updated by the village heads before survey. In seven villages where the map was not available or had not been updated, the list of households was obtained from the 1992 electoral roll which is a less reliable source. To increase the reliability, I updated the list of households obtained from the electoral roll with village heads and other people in the villages before survey.

all households was updated. The houses were numbered serially: the first was chosen by random start followed by selection of every fourth household thereafter. This procedure yielded a sample of 600 households.

Once a household was selected, each interview team approached an adult living in the household for the completion of a household listing form (shown in Appendix A), which gave information about all people living in the household. Each household was visited until all residents aged 15-49 were listed, however not more than three times. If no person in the age group 15-49 was living in a pre-selected household or if none was found at home, that household was skipped without replacement.

3.5.3 Selection of Respondents

From the household listing forms, all individuals aged 15-49 in the selected households were included in the interview. Two call-backs were made to those who were absent at the time of the first interview. Replacement from other households was not allowed if the eligible respondent was not at home or refused to participate. To reduce the number of call-backs, the interview was conducted at different times of the day including at weekends and in the evenings. Each interviewer managed to interview about three respondents per day.[6]

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6. To distinguish the people who were recruited by different approaches, throughout the thesis the term 'respondents' refers to those recruited for the survey, 'participants' those who participated in group discussions, and 'informants' those obtained for in-depth interviews or casual conversation.

3.6 PARTICIPANT OBSERVATION AND GROUP DISCUSSION

One urban and one rural village were selected for further investigations. Heads of these two villages were approached for their permission to let the researcher live in their houses for a month. Selection of the villages was based on the willingness of the village heads to participate in the study. Village life and social events were observed and discussed with the villagers. Sexual relations were explored by participant observation and group discussions (see guidelines for group discussions in Appendix B). As shown in Table 3.1, twelve group discussions were conducted in these two villages. Because of small numbers, it was not possible to conduct a group discussion of single women and only one group of single men was obtained.

Table 3.1 Information about 12 group discussions

Urban village			Rural village		
Group description	Age range	Number of participants per group	Group description	Age range	Number of participants per group
Married women	26-36	6	Married women	35-53	8
	28-41	5		20-34	8
Married men	27-37	6	Married men	27-41	8
	35-49	7		34-51	7
Female secondary school students	16-18	5	Female secondary school students	14-17	6
Male secondary school students	13-16	5	Single men wage earners	16-24	8

3.7 ADDITIONAL SURVEY

In order to understand the family characteristics of the married couples, in December 1994 additional questionnaires were mailed to 99 households where both husbands and wives were previously interviewed. The following information was sought:

1. Whether husbands or wives are original natives of the village.
2. Whether husbands or wives have more relatives of their own than relatives of their spouses in the same village.
3. Whether the family of the husband or of the wife had higher economic status before marriage.
4. Whether their spouses were selected by themselves or by their parents.

3.8 DATA MANAGEMENT

The field survey was completed in mid-December 1993. Although most questions were precoded, further coding was required as many questions were open-ended. After completion of the survey, all interviewers recorded coding of the questionnaires that they interviewed together in a group. The coding process allowed each interviewer to look carefully at his or her written answers in comparison to those obtained from others. The events which occurred during the visits were discussed in detail within the group for further information. Data entry was carried out using the SPSS data entry program. Editing rules were set to detect codes that were out of range. Some descriptive data analyses were carried out using SPSS. The qualitative data consisted of descriptive notes and recorded discussions. The latter were transcribed for later analysis.

3.9 DIFFICULTIES OF FIELDWORK

This section depicts the reality of fieldwork. Some problems and difficulties were solved in the field but others could not be solved, which later affected the response rates and the quality of data as discussed in Chapter 4. These problems are divided into those related to the survey and those related to other approaches.

3.9.1 Difficulties Related to the Survey

Some questions asked in the survey may have offended the respondents even though the wording of these questions had been tested for their sensitivity during a survey pretest. The sensitive nature of the subject may easily cause tension between the interviewers and their respondents. However, a combination of local facilitator and interviewers of both sexes in each survey team had facilitated the survey in many ways. Very few people refused to participate in the survey and most interviews were conducted in privacy. All respondents were informed when first approached that the interview was about their sexual relations and privacy was essential for the interview. Only one respondent was usually available at the time of each visit; therefore, only one interviewer was engaged with the interview. The other interviewer and the local facilitator were helpful in talking with other people who were not selected for the interview, thus preventing them from interrupting. The interviewer also had an opportunity to inform these people about the survey procedure, and useful information was often obtained from discussions with them. People in the villages had gained confidence about the survey from the way we had casual discussions with many of them whether or not they were selected for the survey.

Although it was essential to include a local facilitator in every survey team, three facilitators who could fully assist the survey were available in six villages only. For the rest, only one or two facilitators were available, or were able to help for only a few hours a day. The selection of facilitators was important: people were likely to co-operate if the facilitators were known and respected by them. Village heads and their assistants,

members of the women's committee in the village and village health volunteers were among those working for us as the facilitators. Although we insisted on paying for their time, these people hesitated to take the money as they perceived the survey as a part of their job. In the villages where the facilitators lacked time, we surveyed the areas with the facilitators on the first day, and subsequently visited the respondents later by ourselves. However, night visits were avoided in some areas when the facilitators were not available. Some isolated households were also omitted, or were visited less than three times for safety reasons. As a result, the responses were low in the villages where little assistance was obtained from the facilitators, or in the villages where the houses were spread out over a large area. Chapter 4 gives details about the response rates.

In one village, some households were skipped because of drug problems. Some residents of this village were known to be illicit drug dealers; people from another village informed us in advance about the situation of this village. The village head insisted that drug dealing in the village no longer existed, but we found after the survey had started that these drug dealers had become suspicious about our visits, and subsequently refused to participate. Therefore, some households in this village were skipped for security reasons.

The division of people in some villages had created difficulty in survey co-ordination. There were three large villages which were each prepared to divide into new villages, but the separation could not be made because of lack of funding. Yet people of these villages had already divided themselves into separate clusters. In one village, people divided themselves according to their adherence to the two temples located at opposite ends of the village. In another village, some people lacked trust in their headman who was recently elected. They claimed that the headman was not senior enough for the job, thus some people were less likely to respect him. In the third village, the headman was also mistrusted; the residents claimed that he was not concerned about the welfare of the people. More facilitators such as village health volunteers or senior residents from different clusters were recruited in these villages where the headman seemed to be less respected by the residents. This kind of problem was unforeseen and needed to be solved at once after the survey had started.

Some selected households could not be identified in the actual survey since many households are not located in the adjacent order of number. The identification of selected households in large villages was a problem despite the assistance of the local facilitators or village heads. Either the 1992 electoral roll or a village map was used for household selection; however, the electoral roll was a poor sampling frame: the addresses in it are listed in numerical order not in order of the adjacent households. Therefore, it was sometimes difficult to find the households selected from the electoral roll. The list of names on the electoral roll was taken from the household registration card which refers to *de jure* residence, thus some people were listed in the electoral roll

but were not found in the villages. This resulted in low response rates in the villages where the electoral roll was used.

The survey in the last two villages was disturbed by the rice harvest which normally takes place in early December each year; during this season, most people work together in the rice fields all day long. An exchange of labour is common which means that most people are busy working in their own or their relatives' fields through the whole month. Some households in these two villages were skipped since we felt that these people were tired and should not be disturbed by the interview.

A number of respondents might have been informed of the kind of questions asked before their own interview for two reasons. First, people in the same household might tell the others about the questions: more than one respondent in each household was usually obtained for interview, but the household was usually revisited to interview all eligible respondents who might not be at home at the same time, and those who were interviewed earlier might have told the others about the questions asked. Secondly, people from different households might have told other people in the village what they were asked. The prior knowledge of the people in the villages about the questions was unavoidable, and this caused an interesting reaction: some wished to be interviewed even though they were not selected. Very few people refused to participate, however.

3.9.2 Difficulties Related to Other Approaches

In-depth interviews, group discussions, and participant observation were the qualitative approaches used in this study. Some difficulties occurred with the group discussions. In the third phase, 12 group discussions were conducted in two villages. I myself acted as a moderator in all female groups; for male discussions, a 37-year-old headman who was married and a 35-year-old head assistant who was single were trained to be moderators. A list of questions was given to them and some discussion was tested beforehand. However, it was found later from the voice recording that the participants and the moderators were all familiar with each other. They spoke freely about themselves and the information appeared to be substantially reliable. Out of curiosity, the moderators often asked personal questions that were not on the list; however, the participants were not offended because most of them were friends who knew well about each other's sexual behaviour.

The group discussions were conducted during the period that I stayed in the village for participant observation. After the composition and the purpose of group discussion had been explained, headmen and senior people in the village suggested who should be invited to join the group discussions. However, single women who were income earners could not be obtained for group discussions because very few of them lived in either of the villages.

3.10 FIELDWORK EXPERIENCES

Exploration was the first step of data collection which provided valuable insight and ideas for planning of fieldwork. Some unprecedented subjects such as those about male and female sexual operations, recourse to prostitutes of married men during wives' pregnancy, and some beliefs about AIDS prevention were introduced from discussions with people from various sources. A review of life histories of selected men and women at this stage was beneficial for several reasons. First, the information obtained helped the revision of male and female questionnaires. Secondly, it gave us an opportunity not only to be aware of the sexual life of the people before the actual survey, but also to be particularly cautious about the sensitivity of the questions asked.

Although exploration for basic information was useful, several factors limited the approaches in this step. It took three months for exploration and preparation for the survey, from August to October 1993. Without personal networks with people in the areas, it might not have been possible to interview people as well as to contact the authorities for the survey in due time. Although the information obtained from discussions with prostitutes was extremely useful, access to them was difficult and the interviews raised the suspicions of the brothel keepers. Access to prostitutes can be obtained from contact with local health staff who make regular visits to brothels; however, official contact takes time and effort. The community leaders respected by people in the areas where the brothels are located, were approached as a good alternative to facilitate the interviews with prostitutes in this study.

The selection of appropriate study sites is essential for conducting surveys. It was difficult to accomplish the survey in the remote villages in which night visits were infrequent for safety reasons. Conducting the survey was also difficult in villages close to the city because many people were away from home during the day and they were reluctant to participate after dark. As people in the villages close to town did not return home until late evening, it was felt that the survey might be easier to co-ordinate if the selected villages were further away from the city. The survey village should be far enough that its residents do not commute to the city for work. When selecting a distant village for survey, it is necessary for the survey team to live in the village or in the nearby areas. Doing this gave us an opportunity to build rapport with people in the areas before the survey began. The interviewers had a chance to get to know people in the villages, and to talk with respondents apart from their brief contact during the interviews. People in the village also felt comfortable talking to us about general issues which we hoped would reveal previously unreported or undetected subjects related to the study. However, the survey cost is increased by living in the village.

The questionnaire survey was conducted for one and a half months from November to December 1993. The last quarter of the survey was interrupted by the rice harvest. Although some rural-to-urban migrants return home to help their families with farming

during the harvest season, it was felt that, even if the respondents were available, the interviews might disturb them since most people were already exhausted from farming. The suitable time for survey seems to be during the period before harvest in which many farmers return home from urban employment.

Living in the villages for participant observation gave me an valuable opportunity to observe the dynamics of the village life. Without living in the village, I would not have been conscious that there were very few single women living in the villages, which made it impracticable to organise group discussions of single women in both villages; nor would I have observed the value of higher education among young people in the villages which in turn leads to a social division between students with higher education and young wage-earners.

3.11 SUMMARY

This study combined qualitative and quantitative approaches for data collection. About 40 men and women were interviewed about their life-history and their sexual behaviour. The information was used to guide the survey, to revise the questionnaires, and also to interpret the results in the later stage. Twelve villages from three districts surrounding Chiang Mai city were selected as study sites. About 600 respondents were targeted for the survey. All men and women aged 15 to 49 in selected households were eligible for the interview, but a number of people were not contacted because they were not at home for work-related reasons. Some households were skipped for various reasons such as crime and drugs, isolated locations and harvest season. Some households could not be identified in six villages in which the electoral roll was used as a frame for household selection. The composition of interviewers of both sexes and a local facilitator in each survey team greatly facilitated the survey. Very few people declined to participate. Twelve group discussions were conducted when I stayed in the villages for participant observation in the last phase of data collection.

Although the districts chosen are atypical as they were selected based on the criteria of high levels of HIV infection, the villages studied were randomly selected and were not different from other villages in Northern Thailand in terms of the AIDS situation. The number of people with AIDS who were alive at the time of survey was up to three cases per village. None of these villages required a special care in terms of AIDS prevention control.

A peasant society was targeted in this study; however, some villages obtained are not a typical part of peasant society as previously discussed. Agriculture in the North has been commercialized for decades and, in the villages studied, most of the labour force are in non-agricultural production. However, the characteristics of these semi-rural villages suggest a rural transformation which has been taking place in every part of the country.

CHAPTER 4
Survey Population

4.1 RESPONSES TO SURVEY

A total of 2,632 households were located in the 12 villages selected for the survey. Using the interval of four, 659 households were systematically selected for interview, but interviews were obtained from only 424 households (64% of the target) as shown in Table 4.1 and Figure 4.1.

Table 4.1 Number of targeted households and those actually obtained

Villages	Census used	Total number of households located in the village	Number of selected households[a]		
			Targeted	Obtained	%
Village 1	Map	86	21	15	71
Village 2	Map	221	56	40	71
Village 3	Map	337	85	73	86
Village 4	Map	87	23	23	100
Village 5	Map	169	42	38	91
Village 6	E. roll[b]	156	40	25	62
Village 7	E. roll	328	82	41	50
Village 8	E. roll	181	45	17	38
Village 9	E. roll	185	46	27	59
Village 10	E. roll	248	61	28	46
Village 11	E. roll	181	45	39	87
Village 12	E. roll	453	113	58	51
TOTAL	-	2632	659	424	64

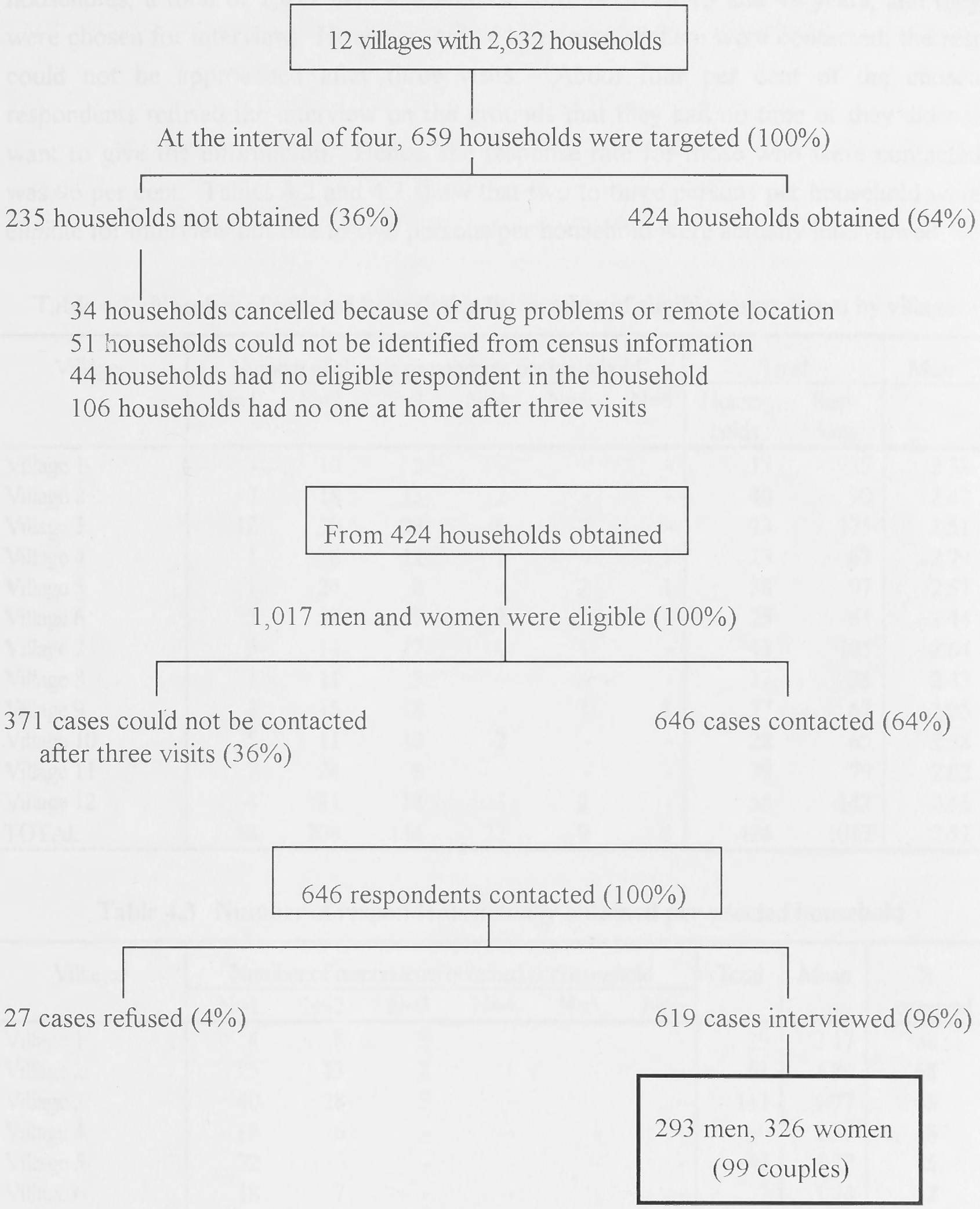
a Number of households expected to be obtained and those actually obtained.

b Electoral roll.

The number of selected households was low in almost every village where the electoral roll was used for census information.[1] They were also the villages where local facilitators were not available to fully co-operate with the survey as mentioned in Chapter 3. Many selected households were not obtained in villages 7, 8, 9 and 10 in particular because there was nobody at home after three visits. These villages are closer to the city and many residents commute to work there. Night visits were seldom made in villages 7, 8, 9, 10 and 12 where the facilitators were not available, and in village 6 which is an isolated village with difficult transport at night. Half of the skipped households were in village 8 where the households were widely dispersed and visits were made fewer than three times. Visits to several households in village 12 were cancelled because of their drug problems, and some households were skipped through the disturbance of the harvest season.

1. In the Thai electoral roll, individuals are listed according to the addresses where their residency is registered. As mentioned in Chapter 3, the 1992 electoral roll provided information about the addresses, and names of all persons aged 21 years and older whose names appear in the household registration record of each address.

Figure 4.1 Responses to the household survey



From the list of all family members who were the usual residents of the selected households, a total of 1,017 men and women were between 15 and 49 years, and they were chosen for interview. However, only 64 per cent of them were contacted; the rest could not be approached after three visits. About four per cent of the chosen respondents refused the interview on the grounds that they had no time or they did not want to give the information. Hence, the response rate for those who were contacted was 96 per cent. Tables 4.2 and 4.3 show that two to three persons per household were eligible for interview but one to two persons per household were actually interviewed.

Table 4.2 Number of selected households by number of eligible respondents by village

Villages	Number of eligible respondents per household						Total		Mean
	N=1	N=2	N=3	N=4	N=5	N=6	House-holds	Resi-dents	
Village 1	-	10	5	-	-	-	15	35	2.38
Village 2	7	18	13	2	-	-	40	90	2.47
Village 3	12	30	23	6	2	-	73	175	2.51
Village 4	1	8	12	1	-	1	23	63	2.79
Village 5	1	24	8	2	2	1	38	97	2.57
Village 6	3	12	7	2	1	-	25	61	2.44
Village 7	5	14	17	4	1	-	41	105	2.64
Village 8	1	11	5	-	-	-	17	38	2.43
Village 9	2	15	8	-	1	1	27	67	3.05
Village 10	5	11	10	2	-	-	28	65	2.58
Village 11	7	24	8	-	-	-	39	79	2.02
Village 12	4	31	18	3	2	-	58	142	2.55
TOTAL	48	208	134	22	9	3	424	1017	2.52

Table 4.3 Number of respondents actually obtained per selected household

Villages	Number of respondents obtained per household						Total	Mean	%
	N=1	N=2	N=3	N=4	N=5	N=6			obtained
Village 1	4	8	3	-	-	-	29	2.17	83
Village 2	25	13	2	1	-	-	61	1.89	68
Village 3	40	28	5	-	-	-	111	1.77	63
Village 4	18	6	-	-	-	-	30	1.37	48
Village 5	32	6	-	-	-	-	44	1.27	45
Village 6	18	7	-	-	-	-	32	1.44	52
Village 7	28	8	5	-	-	-	59	1.78	56
Village 8	13	4	-	-	-	-	21	1.38	55
Village 9	14	12	1	-	-	-	41	1.73	62
Village 10	18	8	2	-	-	-	40	1.70	62
Village 11	26	13	2	-	-	-	58	1.41	73
Village 12	32	20	7	-	-	-	93	1.90	65
TOTAL	268	133	27	1	0	0	619	1.65	61

4.2 EXCLUSIONS FROM THE SURVEY

Over one-third of the people who were not at home during the visits were omitted from the survey: about 60 per cent of them were men who were away from home for work related reasons. Additionally, the survey probably under-represents several groups of people who are less likely to live in the survey villages, such as students in tertiary education, some secondary and high school students and female wage earners. Most students from the survey villages move to the city for tertiary education or better secondary education. Many male and female wage-earners move to town for jobs. Men may commute to work in town and return to live in the villages daily since some selected villages are close to the city. Women are more likely than men to live near their work to avoid the danger of frequent travelling alone. The next section compares the characteristics of survey respondents with the rural population of the 1990 Chiang Mai Census, thus giving the characteristics of people who were omitted from survey.

It is not known whether the behaviour of those excluded from survey was different from that of the survey respondents. The prevalence of premarital sex between men and women exclusively from paid partners reported in this study may be low since a number of single people who are likely to be sexually engaged with their partners were excluded from the survey. People who were not at home after three visits were away from home for work or education related reasons. From lack of parental and community control, a greater proportion of them may be engaged in casual sexual contact with paid or non-paid partners than those living in the village. Chapter 5 explores this potential difference in partner relations between people who move to the city and those who still live in the village.

4.3 DATA QUALITY

The survey questionnaire contains several questions which may lead to inaccurate responses as well as biases created by selective non-response in sample surveys. The survey questions mainly deal with behaviour and it was hoped that these behavioural questions would elicit reliable or consistent responses. However, as pointed out earlier (see Caldwell, Caldwell and Quiggin, 1989; Watkins, 1993), the sensitive nature of some questions makes a structured questionnaire within the typical demographic survey format to collect information about sexual behaviour somewhat questionable. Although this study uses a combination of qualitative and quantitative approaches to cross-check the consistency of the information, a close look at the quality of survey data is crucial before attempting any substantive analysis. The subsequent assessment of survey data quality is following the evaluation of data quality asking about coital activity among reproductive-age women based on the Demographic and Health Surveys program (Chayovan and Knodel, 1991; Blanc and Rutenberg, 1991).

4.3.1 Non-response

Level of non-response is a useful indicator to detect the sensitivity of the questions for both the interviewers who must ask the questions and the respondents who are expected to answer them. To minimise measurement bias, the interviewers only interviewed people of the same sex, and used the northern dialect. However, interviewers and respondents had many status differences such as age, marital status and education attainment. While all except one male interviewer were single men and women in their 20s or early 30s with tertiary education, a large number of respondents were married with only four-year compulsory education. The seniority of the respondents probably led to the interviewers' concern that some respondents might hesitate to give answers or, on the contrary, the interviewers might feel reluctant to ask some questions. Nevertheless, it was found that the only substantial non-response was for two questions about coital frequency and sexual abstinence during the last pregnancy as shown in Table 4.4. The non-response which was caused by not asking the questions was in the interviews of people over 40 only.

Between three and five per cent of the respondents refused to provide information about coital frequency. The level of non-response for sexual abstinence during the last pregnancy was also high; however, non-response to this question mainly came from memory lapse since some people had experienced their last birth a long time ago. Questions about casual sex contact of the respondents with paid or non-paid partners did not appear to be sensitive. The level of non-response to these questions was very low and, as shown in the subsequent chapters, people also talked openly in group discussions about their behaviour with paid and non-paid partners. Some less sensitive questions such as length of marriage and length of time known the partner before the first sexual contact had a high level of non-response because the interviewers lacked interviewing experience in the first few days of the survey. There was a high level of non-response to the question asked of currently married women, whether they think their husbands have had sexual contact with prostitutes; this also was due to lack of experience of the interviewers.

The presence of others at the interview was not a problem in this study as all respondents were informed in advance that the interview required a private discussion. As discussed in Chapter 3, the combination of male and female interviewers and a local facilitator in each interview team effectively prevented the presence of others during the interview.

Table 4.4 Per cent distribution of the response to some questions about sexual relations

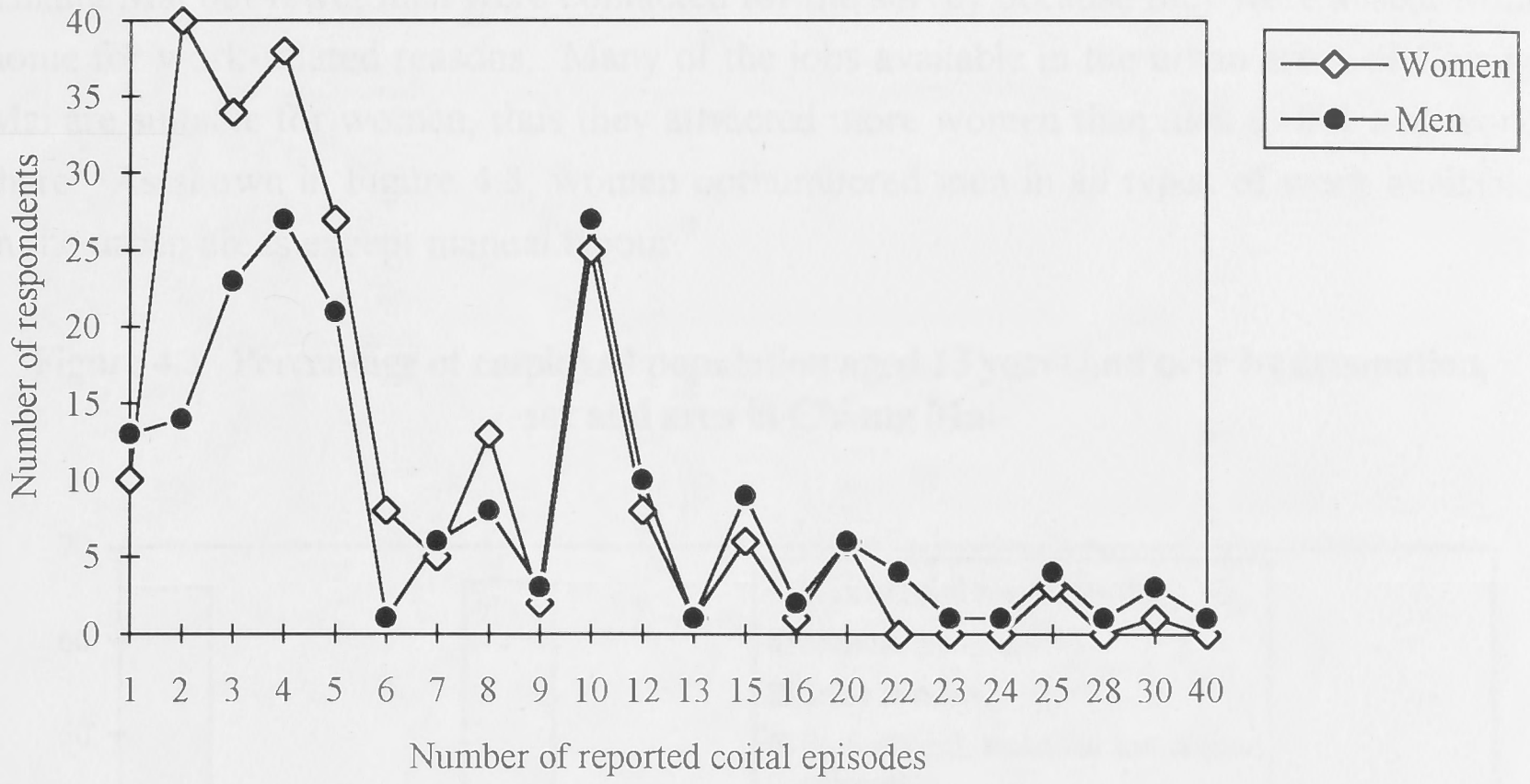
	Provided answers	Interviewer did not ask	Don't know or do not remember	Refused	TOTAL %	TOTAL N
Q 206-Within the past year, how many times per month did you have sexual intercourse with spouse?						
Currently married women	94	1	-	5	100	251
Currently married men	96	1	-	3	100	194
Q 511-Did you abstain from having sexual intercourse with spouse during your last pregnancy?						
Currently married women with a child	94	-	4	2	100	215
Currently married men with a child	96	-	1	3	100	166
Q 601-Do you think you husband ever had sex with prostitutes or not?						
Currently married women	94	6	-	-	100	251
Q 609- How many prostitutes have you paid for sex in a life-time?						
Men ever had sex with prostitutes	98	1	-	1	100	155

4.3.2 Response heaping

The quality of data in questions requiring a numerical response may be indicated by the way in which such responses are concentrated on particular digits. While some heaping may reflect actual patterns, severe heaping is likely to reflect imprecision in response. The response to some questions may be found to be disproportionately concentrated on multiples of the number of weeks in the reference period. A common pattern is a tendency to round responses and report answers that terminate in the digits 0 or 5, or multiples of a month e.g. 4, 8, 12 as shown in Figure 4.2. Several questions such as those regarding coital frequency, number of visits to prostitutes, number of sex partners and number of times infected with STDs required numerical responses, but the concern is on coital frequency only. It is inappropriate to determine response heaping of questions related to casual sex contact because several factors such as age, marital status, duration of marriage, type of partners and attitudes about commercial sex are involved which make it complicated to determine response heaping. From Figure 4.2, heaping of responses on coital frequency is moderate; nevertheless, the degree of accuracy could still be considerable if answers reported were being rounded by only a few coital

episodes. The aim of asking this question was not to produce precise coital frequency but to examine change through time. Consequently, whereas the response may not be entirely accurate, there is no reason to question the direction or magnitude of change. See Chapter 6 for information about coital frequency.

Figure 4.2 Heaping of response on coital frequency per month

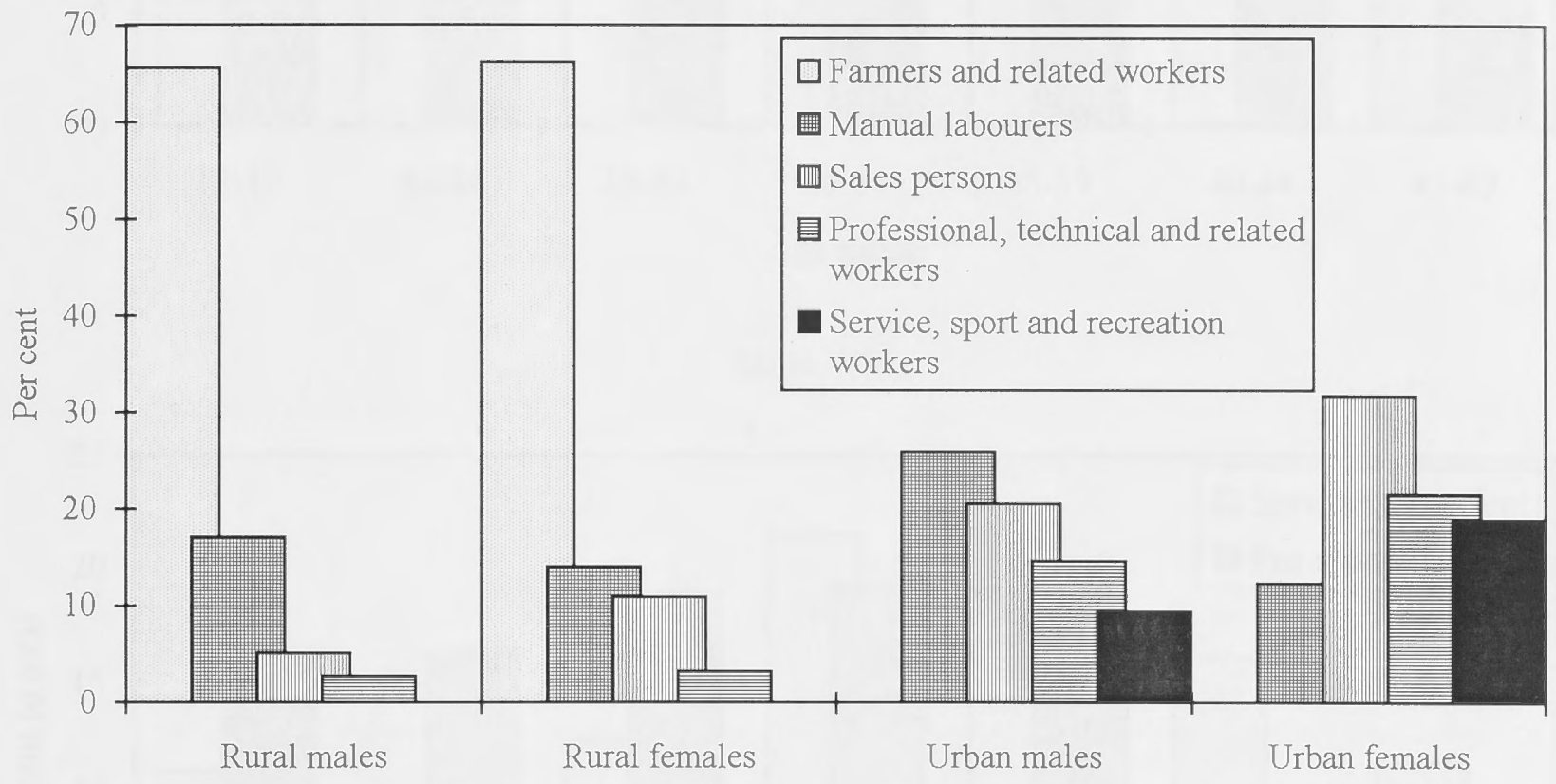


4.4 CHARACTERISTICS OF SURVEY RESPONDENTS

4.4.1 Sex ratio

More women were contacted for the survey giving a sex ratio of 90 men per 100 women. According to the 1990 Census of Chiang Mai, the sex ratio was 105 for men and women aged 15 to 49 in the rural areas and 91 for those in the urban areas (National Statistical Office, 1990: Table 5).[2] Men outnumbered women in the rural areas of Chiang Mai but fewer men were contacted for the survey because they were absent from home for work-related reasons. Many of the jobs available in the urban areas of Chiang Mai are suitable for women, thus they attracted more women than men to live and work there. As shown in Figure 4.3, women outnumbered men in all types of work available in the urban areas except manual labour.[3]

Figure 4.3 Percentage of employed population aged 13 years and over by occupation, sex and area in Chiang Mai



Source: Chiang Mai Population and Housing Census, 1990 (National Statistical Office, 1990: Table C)

4.4.2 Age and sex distribution

The average age of the respondents was 33 years for both sexes. Women outnumbered men in all age groups except in age groups 15-19 and 45-49. In comparison to the rural population of Chiang Mai, the survey under-represented those aged below 30 and over-represented those aged over 30 as shown in Figure 4.3. As discussed previously, a large

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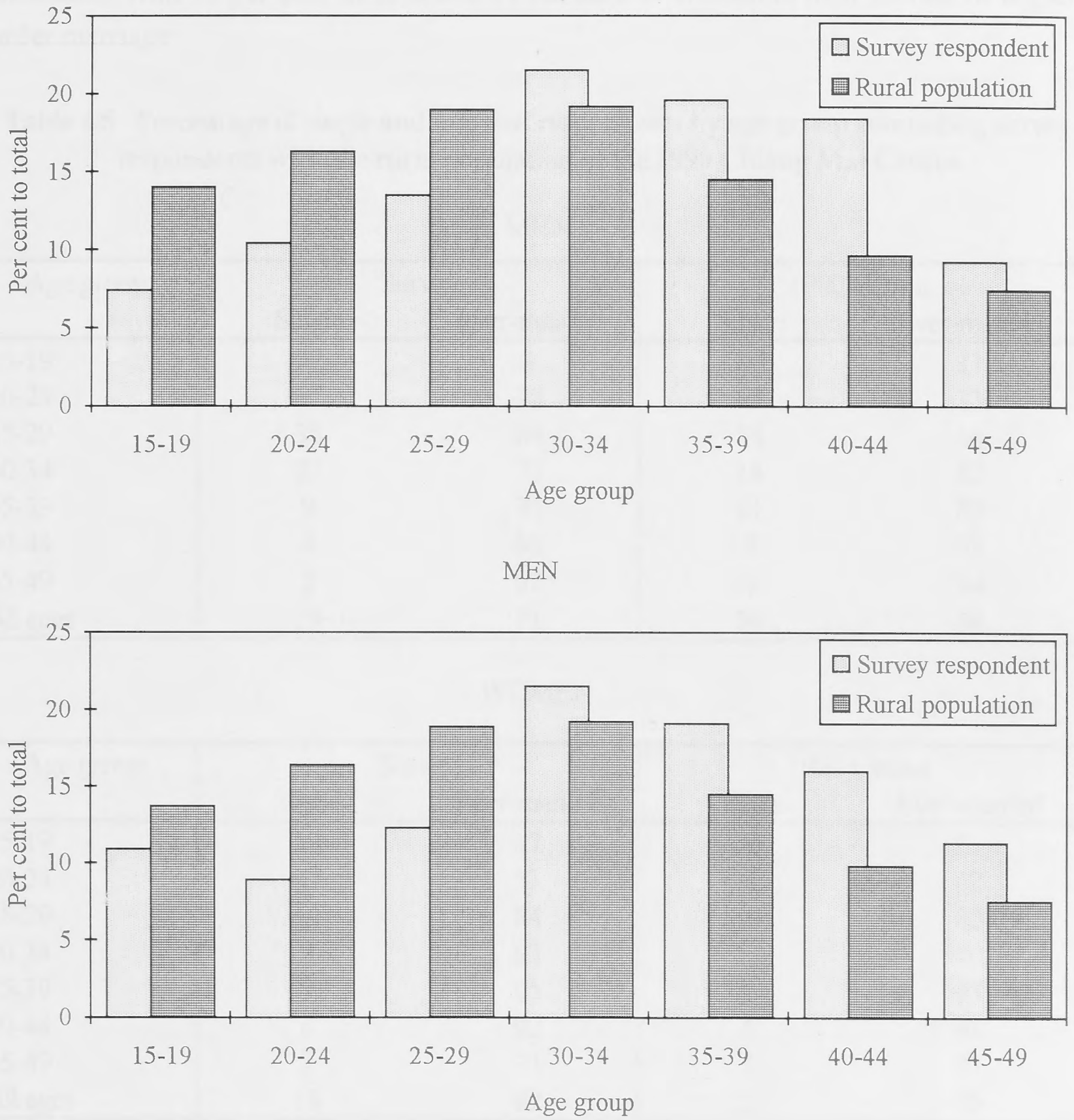
2. Note that, according to the official definitions, all villages selected in this study are defined as rural areas as explained in Chapter 3.
3. The employed population by occupation, age group, sex and area is not available from the 1990 Chiang Mai Census, thus the sex ratio for each occupation group for rural and urban people cannot be calculated.

number of men and women were omitted from the survey for work or education related reasons and many of them were younger than 30 years. The survey over-represented people over age 30 who tend to be married and live in the village and hence they became available for the survey more than younger men.

Figure 4.4 Age and sex distribution - comparing the study sample with the rural population of Chiang Mai



4.4.3 Distribution by marital status

From the 1990 Census, 36 per cent of men and 25 per cent of women aged between 15 and 49 in the rural areas of Chiang Mai were single compared to 29 per cent of men and 18 per cent of women in the same age group who were single in this study. The stratification of marital status by sex and age group comparing between survey respondents and the rural population of 1990 Chiang Mai census is given in Table 4.5. About five per cent of the respondents of both sexes were separated, divorced, or widowed. Among those reported as currently married, the number of remarriages was substantial with 12 per cent of men and 11 per cent of women in their second or higher-order marriage.

Table 4.5 Percentage of single and married respondents by age group comparing survey respondents with the rural population of the 1990 Chiang Mai Census

MEN

Age group	Survey		1990 Census	
	Single	Ever-married	Single	Ever-married
15-19	97	3	89	11
20-24	62	38	67	33
25-29	36	64	34	66
30-34	27	73	18	82
35-39	9	91	11	89
40-44	4	96	7	93
45-49	3	97	6	94
All ages	29	71	36	64

WOMEN

Age group	Survey		1990 Census	
	Single	Ever-married	Single	Ever-married
15-19	83	17	79	21
20-24	47	53	38	62
25-29	16	84	18	82
30-34	7	93	10	90
35-39	5	95	7	93
40-44	8	92	5	95
45-49	7	93	3	97
All ages	18	82	25	75

4.4.4 Education attainment

About 60 per cent of the respondents of both sexes had four years of primary education. Men had slightly higher education than women on average as shown in Table 4.6 which conformed with the National reports (National Statistical Office 1992: Figure 7, 8). The proportion of women with no schooling was slighter greater than that of men and men were more likely than women to have tertiary education. More than half of those with no schooling were older than 30, and about 70 per cent of those with tertiary education were younger than 35.

Table 4.6 Percentage distribution of educational attainment by sex

Educational attainment	Male	Female	Both sexes
No schooling	1	6	4
Primary 1 to 7	70	75	72
Secondary 1 to 6	17	10	13
Tertiary education	12	9	11
Total per cent	100	100	100
Total number	293	326	619

4.4.5 Occupation

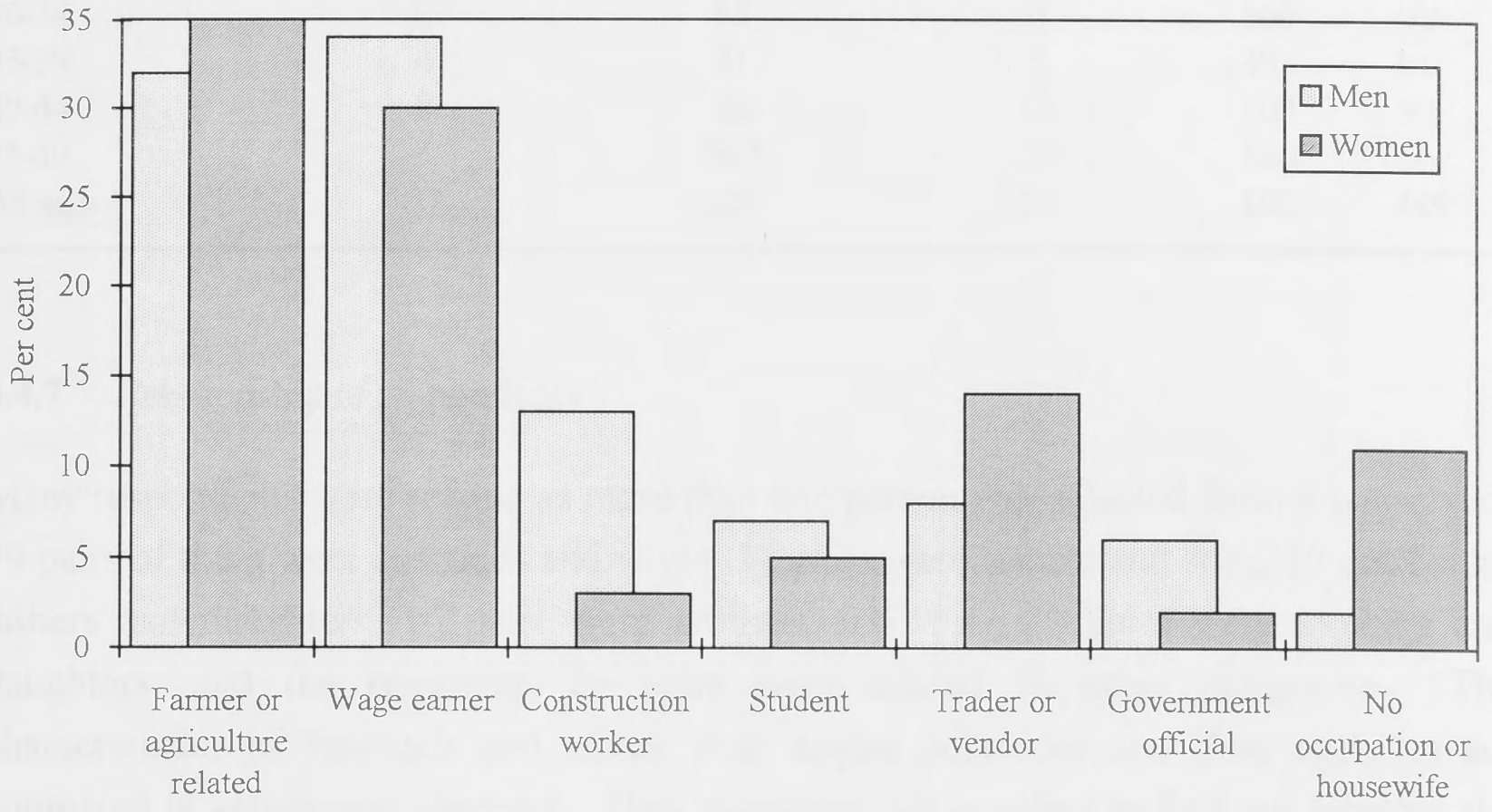
Occupation here refers to the primary occupation which gave the highest income. About 33 per cent of the respondents were self-employed farmers or were in agriculture-related work. The 33 per cent of farmers in the survey villages is much lower than that reported in the 1990 Census enumeration, which indicated that 59 per cent of the population in the rural area of Chiang Mai were in agricultural jobs (National Statistical Office, 1990). The proximity of the survey villages to the city probably leads to the low percentage of people involved in agricultural work.

About one-third of men and women were employed as wage earners in clerical work, sales work, and service work. About 10 per cent of the respondents were engaged in construction work which was in high demand in Chiang Mai. The income received from construction work is stable and may be worth more than that received from farming; hence, some farmers claimed construction work, not farming, to be their primary occupation.

The range of occupations reported by the respondents may reflect the characteristics of the survey villages. Some occupations were concentrated in particular villages, for example most people who were employed as government officials came from villages surrounding the city like villages 2, 7, 9, and 10. More than 70 per cent of the respondents from village 10 were reported as wage labourers. This village was well known for silverware handicraft, and most workers worked at home. The number of farmers was higher than average in rural villages including villages 3, 4, 5, 6, 11, and 12. The number of respondents who were students was highest in villages 2 and 7 which are

urban villages. About 25 per cent of the respondents from village 11 claimed to have construction work as their primary occupation. About 20 per cent of the respondents from village 1 were employed for the construction of a high-rise condominium being built near the village.

Figure 4.5 Occupational distribution by sex



4.4.6 Number of children and siblings

The respondents have four siblings on average but the mean number of siblings increased progressively with age as shown in Table 4.7. More than 60 per cent of the respondents aged over 24 reported having more than three siblings. The number of living children declined by age as shown in Table 4.8 and this supports the claim that Thai fertility has started to decline in the past two decades (Knodel, Chamratrithirong and Debavalya, 1987).

Table 4.7 Percentage distribution of the number of siblings of respondents by age group

Age group	Number of siblings			Total	
	0-2	3-5	>5	%	N
15-19	81	17	2	100	56
20-24	57	33	10	100	60
25-29	34	49	17	100	80
30-34	33	44	23	100	133
35-39	32	50	18	100	120
40-44	27	50	23	100	107
45-49	29	42	28	100	63
All ages	39	42	19	100	619

Table 4.8 Percentage distribution of number of living children of ever married respondents by age group

Age group	Number of living children			Total	
	0	1-2	>2	%	N
15-24	55	45	0	100	29
25-29	20	77	3	100	56
30-34	15	85	0	100	105
35-39	4	91	5	100	107
40-44	8	82	11	100	92
45-49	5	76-3	21	100	56
All ages	57	358	30	100	445

4.4.7 Relationship of respondents

Many respondents were related as more than one person was selected from a household: 99 pairs of them were husbands and wives, 17 pairs were fathers and sons, 10 pairs were fathers and daughters, 16 pairs were mothers and sons, 20 pairs were mothers and daughters, and the remaining 29 pairs were related in other categories. The characteristics of husbands and wives, their sexual behaviour and their attitudes are compared in subsequent chapters. Their responses are matched to find out whether the wives had any knowledge of their husbands' sexual relations with other women.

4.4.8 Household income

The household income was the net income earned by all household members. The average monthly income per household was about 2,700 baht (A$130) which was less than half of the average monthly income of the Chiang Mai residents reported in 1990 at 4,553 baht ($A230) (National Statistical Office, 1992: Table 66). About seven per cent of the respondents said that they had irregular incomes. Villages 1 and 12 had the lowest monthly income per household, while villages 2 and 10 had the highest. The income earners for the family were largely the heads of the household and their spouses. The respondents from only two households reported that the children were the major income earners of the household.

4.5 SUMMARY

The survey interviewed 619 men and women aged between 15 and 49 selected from 12 villages. In comparison to the rural population of Chiang Mai, the survey has more men and women aged over 30. The survey omits a large number of men and women under 30 because they were not at home after three visits. There is no effective way to assess how behaviour may differ between those omitted and those included in the survey. However, some types of behaviour such as casual sex contact, type of partners, or frequency of contact may differ between the two groups. For instance, single people who were

omitted from the survey may have more freedom to have sex with prostitutes than those reported in the survey, from lack of parental or community control. The low non-response rate does not indicate the accuracy of survey data. However, information derived from qualitative approaches was crucial for cross-referencing the information. The presentation of data and the interpretation of results in the subsequent chapters combine the information from both the qualitative and quantitative sources.

CHAPTER 5
Courtship and Partnership Formation

The content of this chapter is divided into three related subjects: courtship traditions and factors which led to the growth of prostitution in Chiang Mai; the marriage pattern of people in the rural areas; and the potential marriage squeeze on rural men. It focuses on how young people in the rural areas develop their relationship with the opposite sex and how prostitution has subsequently flourished in Chiang Mai. The traditional society is contrasted with current society to explore changes in sexual behaviour over time. The traditional beliefs and values which once prevented premarital sex are explored, and constraints on partnership development are indicated. Modernisation, migration of young people from rural to urban areas and improved educational status are the factors used to explain how traditional values disappear and are followed by changes in the courtship behaviour of the younger generation. Single men are finding it increasingly difficult to have relationships with non-prostitute partners, which subsequently promotes their liaisons with prostitutes. The development of prostitution in Chiang Mai is given attention to show the rapid increase in demand for prostitution by local men. To address the potential difficulty of men in finding suitable partners, the marriage pattern of people in the rural areas is explored by comparing the socio-economic characteristics of husbands and wives before marriage. This is followed by the calculation of sex ratios to detect the surplus of single men and women using the 1960 to 1990 censuses.

5.1 NORTHERN COURTSHIP IN THE PAST

Traditional courtship among the Northern people is less apparent now. However, it is necessary to examine courtship in the recent past to understand the transitional changes in courtship behaviour of people in the younger generations. The term *aeo-sao* is usually used for brothel visits by the Northern men. However, this term was used in the past to mean the courtship behaviour of young men who would roam around in group visiting the single women. This tradition is known to many ethnographers and local experts as practised by young people in the Northern villages in past decades (Chaiyaworasilpa, 1964; Nimmanhemin, 1970, 1987; Chotisukharat, 1971; Turton, 1972; Potter, 1976; Potter, 1977; Wannasai and Nimmanhemin, 1978; Mougne, 1981; Payomyong, 1985, 1986). Boys would go group-courting when they became teenagers; they usually visited the girls at their houses at night. Some would take musical instruments with them to recite love poetry for the girls. Examples of love poetry used for the Northern courtship can be seen in much Thai and English literature (Wijeyewardene, 1968; Potter, 1976:105; Potter, 1977; Mougne, 1981: Appendix 8; Payomyong, 1986: 146-153). The following is a description of the practice and suggests that this tradition was still being practised in the 1970s (see Potter, 1977: 103-114).

> ...it is the boys and young men who take the initiative by going to the girls' houses to visit them at night after the day's work is done. *?ewsaawing*[1] also takes place at temple fairs, ordinations, funerals and other occasions that boys and girls from different villages become acquainted and make the contacts that later lead a boy to go visiting a girl at their home.
>
> After dark on almost every evening of the year when the weather is good, the roads and paths of the countryside near Chiangmai village are filled with groups of men, ranging from teenagers to experienced young men in their twenties, all going to visit girls in the same village or in neighbouring ones. Boys are always in groups of two or three; they never go alone because men from other villages have been known to waylay boys who are courting girls from their village. Sometimes these encounters are deadly, since the boys take along knives and guns to protect themselves or for other less praiseworthy reasons. Also, gangs of boys from different villages not infrequently stage pitched battles over girls and to express high spirits. Chiangmai [name of the village under study] fought a neighbouring village in 1971, and relations have been strained between the two villages ever since. One of the first orders the new acting district officer gave when he assumed his post in 1972 was that the carrying of knives and other instruments of war by boys going to *?ewsaaw* had to stop.
>
> Potter 1976: 104

After dark the unmarried women would stay at the outskirts of the house waiting for the young men who approached to help them with the night's work. They might work and exchange conversation until late at night. However, the men could neither touch any part of the woman's body nor go beyond the sitting area throughout the visit, otherwise this would upset the ancestor spirits and cause illness to the women's relatives as described below. Once they had decided to marry, the senior relatives of the men would ask the woman's parents for marriage arrangements.

The traditional courtship was not as easy a process as it sounds. The difficulties of this courtship process have been noted before (Potter, 1976; Potter, 1977). Since women wait to be approached by men in this traditional courtship, some women may lack trust because they never know whether or not their boyfriend is faithful to them. Secondly, the process of this courtship may not make it easy for some people to form a relationship with the opposite sex. For instance, a less attractive woman may have only a small chance to be approached by men; or, similarly, some shy men may be intimidated by their friends from forming a relationship with the women. Moreover, this traditional courtship has also limited the circle of eligible partners for both sexes. If a man is interested in a woman who lives in another village, he needs to gain acceptance from the woman's community first, otherwise the couple may not be able to form the relationship successfully. Thirdly, the woman's parents play an important role in selecting their son-in-law since the traditional courtship usually takes place at the woman's house. The woman's parents also have strong influence on the selection of their son-in-law because a husband in the rural areas usually moves in to live with his wife's family after marriage to help them with farming. Thus the traditional courtship may not allow women to select husbands by their own choice (Nimmanhemin, 1981: Podhisita, 1983).

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1. The spelling here refers to *aeo sao*(ing) written in a different script.

5.1.1 Spiritual Beliefs in Control of Sexual Morality

Many kinds of spiritual beliefs once limited the sexual relations of people in the Northern region as pointed out by some ethnographers (Turton, 1972; Davis, 1973, 1974, 1984; Potter, 1976: Potter, 1977; Mougne, 1981; Nimmanhemin, 1981, 1987; Irvine, 1982; Cohen and Wijeyewardene, 1984; Rhum, 1987).[2] The ancestor spirits or *phii puu njaa* have gained much attention especially regarding their direct function in the control of sexual morals. This important role of the ancestor spirits was documented over a hundred years ago by a British historian who recorded that in 1878 the first Christian wedding of local converts was interrupted by demands for payment for a feast to the spirits. Chiang Mai's ruler refused to intervene in this conflict but King Rama V later issued a royal proclamation stating that the custom of feasting the spirits was left to individual conscience (Bristowe, 1976: 60-61).[3] How spiritual control determined the marriages and partnerships of people in the past is described below:

> The most common and serious offence against the *phii puu njaa* is called *phid phii* (literally, 'wronging the spirits'). If a man commits any form of sexual misdemeanour, ranging from mere bodily contact to intercourse, with a woman with whom he does not have an approved union, the spirits of her cult group will be offended. Such transgressions require that the offending male provides money for the girl's group to purchase a pig's head as an expiatory offering to the spirits (*sia phii*). In the past this fine took the form of a customary number of rupees if the man decided to marry the girl (*sai aw*) and double the amount if he chose not to marry (*saj bau aw*). Nowadays the latter is rarely fixed and varies according to the wealth of the man and/or his parents.
>
> Cohen and Wijeyewardene (1984: 249-250)

> Technical sexual trespass includes a man stepping over the threshold of a girls' family bedroom or touching any part of her body, even by sitting on the same mat. A girl will roll a cigarette for her suitor but offer it holding the extreme tip.
>
> Turton (1972: 232)

When sexual misconduct occurs, the ancestor spirits work through the woman's side by causing death or illness to the woman's relatives. From this, the woman's parents would know that their daughter is having a secret relationship. The parents may also consult the spiritual mediums, who often suggest sexual misconduct as the cause of illness.[4] The ancestor spirits do not cause any harm to the offending men but the girl's parents demand a marriage, or a compensation from the man or his parents to give a feast to the

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2. The Dai or the Thai people, who live in Yunnan province of South China, people in the rural area of northeastern Thailand and in Laos follow a similar courtship tradition and they also believe in the sanctions of the ancestor spirits (see Keyes, 1984: 230; Liangwen, 1992).

3. Although Chiang Mai has been part of Thailand since 1868, the kingdom had its own ruler and administration until the early 20th century (Soonthonphesat 1970: XX). The refusal to sanction the marriage by the Chiang Mai king during that time was believed to be an opportunity to expose the commissioner's lack of power even though he represented the Thai king (Bristowe 1976: 60-1).

4. The spiritual mediums, or in the northern terms: *ma khi* - a horse to ride, or *chao song* - a god medium, have strong influence on the people's beliefs, as observed from fieldwork. Two survey respondents and one headman were spiritual mediums. Between one and three spiritual mediums were found in each survey village.

spirits. It is not clear what would happen if the man refused the responsibility. However, this situation may be rare because the structure of the peasant societies provides an extensive network of relatives and neighbours who will prevent the man from being irresponsible. Nevertheless, an increasing number of women from the rural areas are now being approached by men from distant areas which in turn limits the control of the peasant networks. This probably leads to the decline in belief in the control of the spirits in recent years.

The spiritual control of sexual behaviour in the Northern culture is flexible, which is in agreement with an observation in the early years that Thailand is a loosely structured society in which not many rules are firm (Embree, 1950). For instance, sexual contact in some parts of the house is ignored by the spirits (Davis, 1984:60). Despite the control of the ancestor spirits, sexual relations by the young people before marriage have occurred away from home in the forest or a hut in the rice field, or in recent years in a nearby motel (Turton, 1972: 232; Mougne, 1981: 415). An example of feasting the spirits in recent years can be seen in a life history review of a man with AIDS (case study number 6 in Appendix D). Although the girlfriend of this man was a former prostitute, the parents of the woman still demanded that he should pay money for the ceremony when the couple had decided to live together. The amount of money was small (A$25), only enough to buy a pig's head for the ceremony. The practice in this case has raised an interesting point, that being a prostitute may have not been perceived as an act of sexual misconduct. *Sia phii* is not required when a woman enters prostitution unless she has later decided to live with a man as husband and wife. The practice seems to be a ritual ceremony to approve their union as described below:

> *Phid phii* or *sia phii* cannot be interpreted as bringing about a marriage; it is only a preliminary. After *phid phii* and *sia phii* are completed according to custom, there still must be a wedding ceremony (*kaan tengngaan*) or as the Northerners say, the 'feeding of the guests (*kin khaek*)'. But if the parties are very poor, they may only perform the ritual of *sia phii*, this is sufficient.
>
> Chotisukharat (1971: 218)

5.1.2 Disappearance of Traditional Beliefs

Some people in this study claimed that the control of the ancestor spirits had limited their relationship with the opposite sex in the past. Most people similarly agreed that people in the younger generation no longer have such beliefs. However, some parents still had a belief that the ancestor spirits might have some effect on them if their children had committed sexual misconducts.

> Moderator: Does anyone believe about *phid phii* when one commits sexual misconduct?
> 1st man: It's not important now [agreed by everyone].

2nd man: There is no longer such belief. But in the past even throwing a handkerchief to the women's lap would upset the spirits. Taking a woman to sleep with inside the house upset the house spirit. Look at what's happened now: hugging and kissing are no longer *phid phii*. Young people now ask back, what are the spirits?

Rural village, Single men

Don't even mention about holding hands or sitting on the back of motorcycles [in which men and women become physically close and, therefore, commit *phid phii*]. In my time, men were not allowed to enter the women's room, except those who were related. Men could not just simply visit their girlfriends at any time like these days.

Married man, 43

Moderator: Do children believe about *phid phii* these days?
Everyone: No, there are no longer such beliefs.
1st wom: But the spirits still exist, those who commit wrong-doing will be cursed.
2nd wom: An example about the influence of the ancestor spirits - if the children commit wrong-doing and cause troubles, one may need to consult the spiritual mediums. Then you find out whether your children have committed *phid phii* or not. This follows by having a feast asking the ancestor spirits for forgiveness.
3rd Wom: There is no belief about the ancestral spirits now.
Everyone: It depends on generations. Sometimes when unexplained things have happened, one still needs to ask the spiritual mediums for advice.

Rural village, married women

Belief in the ancestor spirits no longer has effective control on partner relations of people in the young generation. However, most Thai children are still brought up with a belief that women should be conservative with the opposite sex. The parents are much concerned about the sexual behaviour of their daughters, and are less concerned about the sexual behaviour of their sons.

Moderator: What do you think about women these days?
1st wom: Ah ha.....Just like a Hitachi [5] .....(laughs)..... How should I say? Women these days are not concerned that they should be careful [about men]. Unlike women in my generation, men and women could not be even near each other otherwise it would *phid phii* or upset the ancestor spirits.
Moderator: Do the spirits still exist nowadays?
2nd wom: Of course, but young people just ignore them.

Urban village, married women

My parents would not allow me to go out at night. I had to be home by 6 p.m. I only let my boyfriend hold hands, nothing more than that.

Female university student, 19

I was not allowed to go out at night unless with several friends. A few men were interested in me but they dared not come any closer. It is difficult to be a woman, one must have self-control otherwise she will be called an easy girl and will lose her value. Men are

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5. Women at the present time responded to men's seduction too easily, just the way the Hitachi rice cooker works. The advertisement for this product is well known: *kot pup tit pap* or 'turns on promptly once the button is presse'.

different from women because they can be sexually experienced. They gain, not losing anything (from having sexual engagement with women).

Married housewife, 37

5.2 FACTORS LEADING TO CHANGES IN COURTSHIP BEHAVIOUR

5.2.1 Modernisation and Migration

Differences in cultural belief have contributed to the disappearance of beliefs in the effect of the ancestor spirits on sexual relations. An increasing number of people from the other regions have moved to live in Chiang Mai because the city has a good potential for economic growth. However, these people are not familiar with some Northern cultures. When the traditional practice of feasting the spirits was revealed to them in the early years, the Northern women were insulted and stigmatised as easy girls or cheap sex toys since only a small sum of money was required after a man committed sexual misconduct (Chaiyaworasilpa, 1964; Nimmanhemin, 1970).[6]

The practice of traditional courtship has died out with modernisation as exemplified by things such as electricity and modern transport which have reached many rural areas in recent years. Many families in the rural areas can afford to buy a motorcycle for their private transport so after dark young people no longer roam around in the village or the neighbourhood as before. An increasing number of men and women are looking for employment in towns. Over the same period, several kinds of prostitution have developed rapidly in the urban areas of Chiang Mai as described in the next section. The custom of *aeo sao* has changed its traditional meaning from a group courting of young men for conversations with women to a group visit of young men for casual sex with prostitutes.

An increasing number of young men and women in the rural areas have become the breadwinners of their families. Many of them have moved into town because manufactured products are in large demand for the growing industry in Chiang Mai. Many children in the rural areas are no longer financially dependent on farming with their parents as in the past. Their economic independence is perhaps one of the factors enabling young men to pay for sex more than before, and perhaps for young men and women to engage in premarital sex without the fear of punishment from the ancestor spirits as in the past. Many women perceived that the availability of modern contraception has led to the sexual revolution of people in the younger generation:

Moderator: What do you think about women these days?

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6. It is a common practice for all Thai men to pay money to the women's parents to express their gratitude. However, the payment of the ancestor spirits is not a brideprice. The small payment for the feast of the ancestor spirits is only enough to buy a pig's head, chickens, or alcohol for the ancestor spirits, as indicated by Nimmanhemin (1970). However, people from the other regions misinterpreted the practice and thought that the northern parents sold their daughters at low cost. Although some parents in the northern villages still demand the payment for the spirits, bride-price has been widely adopted in Chiang Mai for many years just as marriage customs practised elsewhere in Thailand.

1st wom: In the past, there was no pill, right? It was a big embarrassment if a woman got pregnant without the presence of the father of the baby.

2nd wom: Young women now are clever. If she took the pills and behaves well enough, nobody could catch her [know that she is sexually experienced].

Moderator: Should women be possessive with their bodies?

3rd wom: Of course, those who do not believe in the traditional beliefs [ancestor spirits] would be cursed.

4th wom: No. No. The children don't care now. Like in my son's case, two to three years ago, he took a friend from school to sleep with [at home] but he told me that they were just friends.

Rural village, married women

Even though it is likely that migration would lead men to seek casual sex when they are away from home, it was found that on indicators of sexual experience there is little differences between migrants and non-migrants. All respondents were asked about their homeplace and whether they had ever migrated to provinces other than Chiang Mai after age 15. About 90 per cent of male and 87 per cent of female respondents claimed to have a homeplace in the rural areas of Chiang Mai. After those who were not from Chiang Mai were excluded, only about 10 per cent of females and 19 per cent of males said that after age 15 they had ever lived in areas other than Chiang Mai for one year or longer. However, the migration estimate here has a limited interpretation for two reasons. First, the survey probably excluded a significant number of people who could not be contacted during the survey for work-related reasons; therefore, this migration estimate is likely to be under-reported. Secondly, it is likely that a number of people in the rural areas may seek casual employment outside the village for a short period rather than a long one. These people may live outside their village for a short while but less than one year. However, they were not defined as migrants because migration here is defined as being away from their place of usual residence for at least one year.

Among those reported as having migrated to provinces other than Chiang Mai for at least one year after age 15, half spent some years in other Northern provinces, one-tenth in Bangkok and the rest in other regions. Most of them said that they had migrated to the other areas for work related reasons. About half were away for less than two years. However, migration did not make any difference to men's and women's sexual experience. No women with past migration reported having had sexual relations before marriage. The lifetable median age at first intercourse of men with past migration is similar to that of those with no migration (18.7 and 18.5 years). The proportion of men who had ever had sex with prostitutes was similar whether or not they had previous migration: 81 per cent of men with no migration compared to 83 per cent of men with past migration had ever had sex with prostitutes; about 56 per cent of men with past migration and 59 per cent of men with no migration had prostitutes as their first sex partners.

5.2.2 Division of Social Network Among Young People

The division of social network among the children and young adults in the rural areas has been observed from participant observation in two villages. The different levels of their educational attainment have facilitated the division of their social network. Many parents in the rural areas encouraged their children to go beyond compulsory education; however, it was found that the more educated the children were, the more selective they became in their choice of friends. Those with higher education preferred to socialize with friends who were compatible to them in education background. This has resulted in a division of social networks among young people in the villages into two groups: the students who continue in higher education and the non-students who left school and became wage-earners at early ages. The former were mostly financially dependent on their parents and the latter were self-supporting and usually sought income to support their parents and siblings as well. Prostitutes often claimed that the money they earned would enable their siblings to go on to higher education. The courtship behaviour of young people in these two groups is different as described below.

In three group discussions of male and female students, most expressed little interest in having a boyfriend or girlfriend when they are still in secondary school. Only one or two persons per group said that they had already had a boyfriend or a girlfriend.[7] The expression of little interest in the opposite sex by students in the rural areas was not surprising as those who joined the discussions were mostly in grade 9 and upward, or aged 16-17. Many Thai students in these grades were anxious about the approaching national examination for tertiary education which takes place at high school. The highly competitive education market had led many students to take extra classes at the tutoring schools. Many students from the rural villages would travel to town for tutoring on the weekends like city students. Their engagement with intensive study at this stage probably made them less interested in forming a relationship with the opposite sex. Unlike male students in the recent past who usually visited brothels at about their ages below 20, many male students had postponed their first intercourse because of their fear of contracting AIDS. All male students said that they preferred to have girlfriends, not prostitutes, as their first sex partners. Female students also expressed little interest in forming a relationship with the opposite sex at their age. They prefer to establish a relationship once they have become successful in higher education or have secured a good career. The rural youths with higher education were expected by people in the village to become successful more than their friends who were not able to continue higher education.

An increasing number of children in the rural areas go beyond compulsory education now since most families have only two children. However, the educational system in

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7. Unlike those from the rural village, students from the urban village claimed that it is common for their school friends to establish a relationship with the opposite sex at young age. However, they said that those with girlfriends or boyfriends tended to live separately from parents.

Thailand is not yet well developed to promote higher education outside the urban areas. Many students from the rural areas need to travel for a long distance to schools because there are very few secondary schools in the rural areas and many rural schools are of poor quality. Some parents in the rural areas send their children to live in dormitories or to live with relatives in town for better schooling. In group discussions, most students of both sexes claimed that between one-third and half of their classmates had lived separately from their parents even though they were only 15 to 18 years of age, and these students are likely to have boyfriends or girlfriends earlier than their friends. Of those who still lived in the villages and commuted daily to schools in towns, all would move to the cities when they went on to tertiary education in their late teens. However, all parents similarly agreed that young people who are away from their parents are likely to engage in sexual relations with friends because of lack of parental control.

Moderator: Why did the girl come to sleep with your son?
1st wom: Young students live in dormitories now. If they stay out late, they could not get into the dormitory. They just come to sleep together.
2nd wom: My son took a girl to sleep with at home and tried to hide it from me. I told him to be careful of AIDS, but I found condoms in his pockets...(laughs).....I saw a condom float downstream [from the hut] when I washed the clothes in the canal.
3rd wom: My son was 16 and took girls to sleep with at home. I don't know what kind of girls they are.
4th wom: You should tell him to be careful of AIDS.

Urban village, married women

Some female students claimed that their male friends no longer wish to go to brothels because they can have sexual relations with their school-friends. A few of them had friends at school who had an abortion for unwanted pregnancy. However, the type of schooling may differentiate the level of sexual relations among school students. For instance, as claimed from student group discussions, students of vocational or commerce colleges are more likely to engage in premarital sex than students from other types of schooling (see also Sakondhavat et al., 1988). Tertiary education of this type provides co-education for adolescents who have just completed secondary education, and it takes three to six years for students to complete a diploma course. Some evening classes are available for students who may work during the days as well. In another type of schooling, the students complete high school and many of them compete for the national examination to get a place in the highly competitive public universities. From a large survey questionnaire of young single men, a recent study found that male students at the university level have postponed their age at first intercourse through their fear of contracting AIDS from sexual relations with prostitutes (VanLandingham et al., 1992). In-depth interviews showed that some university students had sexual relations with friends by own choice; however, most female students expected their partners to marry them when they graduated (see life-history of selected individuals in Appendix E).

> It is common these days to have sexual engagement with boyfriend before marriage. Many of my friends do this. I have been sexually engaged with my boyfriend since I was in the

first year. Condom use is not necessary because we know each other well. He uses withdrawal to prevent pregnancy.

Single female student, aged 26

I have always been a good student until I met my boyfriend in the second year. We had been together for one semester before we experienced first coitus.

Single female student, aged 22

I did not want to be sexually engaged with my boyfriend but he insisted. He promised to marry me when we graduate and we later had sexual intercourse.

Single female student, aged 21

Men who had suspended their education and became wage-earners at early ages were more likely to be sexually experienced than male students of the same age. While 62 per cent of male students aged below 25 had never had sexual experience, about 73 per cent of single male wage-earners aged below 25 had already had sexual experience (risk ratio=1.92, 95% CI=1.06, 3.47).[8] The type of partner at first sexual intercourse of men in both groups is different but has no statistical significance. Among those with sexual experiences, about 37 per cent of students and half of wage-earners had prostitutes as their first sex partner. Half of students and 30 per cent of wage-earners had their first sex with girlfriends, and the rest were with casual female partners. Chapter 6 gives information about men's first sexual experience.

The information about the sexual behaviour of single women who are wage-earners is limited since very few of them were found in the villages. This group of women tends to work and live in town, and occasionally visit their parents and relatives during festival times. However, women in this group are likely to be sexually experienced before marriage from lack of parental control (see Ford and Saiprasert, 1993).

5.3 DEVELOPMENT OF PROSTITUTION IN CHIANG MAI

Prostitution has developed rapidly in Chiang Mai along with the decline in traditional courtship and beliefs about the spiritual control of sexuality in the past years. Early historical and ethnographic literature indicates that prostitution in Chiang Mai has its own development which is distinctive from the development of prostitution in Central Thailand. The following describes the rapid growth of prostitution in Chiang Mai, and explains why a large number of women from the Upper-North region enter prostitution in contradiction of their traditional beliefs about sexual relations.

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8. The lifetable median age at first intercourse of male students is two years earlier than male wage-earners (15.4 and 17.9 years). For single men younger than 25 years old, the mean age of students and wage-earners is equal at 18. There are 21 male students and 26 male wage earners who are younger than 25. However, male students with sexual experience are few and those with sexual experience had the experience at a very early age.

5.3.1 History of Prostitution in Chiang Mai

Even though the history of prostitution in Central Thailand can be found elsewhere (see Bamber et al., 1994; Thitsa, 1980; Boonchalaksi and Guest, 1994), the development of prostitution in Chiang Mai is not well documented. While STDs were quite common in Bangkok between 1836 and 1910 reflecting the existence of prostitution there at that time (Bamber et al., 1993: 180), no history record suggests that STD infections were of great concern in Chiang Mai during that time. According to the anecdotal record by Dr. Daniel McGilvary, an American Presbyterian missionary who ran a mission in Chiang Mai from 1867 to 1898, only malaria, goitre and smallpox were mentioned to be the diseases of concern then (McGilvary, 1912: 88-89; Bristowe, 1976: 70). In the late nineteenth century, which was the period of King Rama IV of Siam, King Kawilorot of Chiang Mai demanded that prostitutes and *kathoeys* or men acting like women be severely punished (Chiyaworasilpa, 1964: 313-321: Institute for Population, 1994b: 13-14).[9] In 1890, the harem which was adopted by foreigners was known as an early kind of prostitution in Chiang Mai (Chiyaworasilpa, 1964; Bristowe, 1976: 82-83). Some local women were willing to join this harem for the economic improvement of their family in the way that some women are motivated to become prostitutes at the present time:[10]

> Brothels or casual prostitutes like those in Europe scarcely existed [in 1890s]...the attractions of local girls gave rise to the collection of a sizeable harem. This was all too easy for an unattached man, to whom a father would offer his daughter in return for a couple of buffaloes provided he gave her a home with food, clothes and pocket money...Farmers were pleased with the honour and delighted with the buffaloes they had received in exchange for their daughters, while the girls were fully contented with their lives of ease, reinforced by pocket money, nice clothes and even jewelry if they behaved themselves. The owner of a harem was admired by the local people in Chiang Mai for the wealth and virility which this implied.
>
> Bristowe 1976: 78, 82-83, 141

After the introduction of this harem, a typical brothel like those in Bangkok at that time is believed to have operated in Chiang Mai for the first time in the 1890s, run by a

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9. This suggests that prostitution may have existed in Chiang Mai before the 1880s. *Mae- kamlang*, one of the 12 kinds of wives in the ancient Lanna laws, is believed to be the first kind of prostitution in Chiang Mai in the old days. Men paid to have sex with this kind of woman for a certain period. However, other men could not have sexual engagement with this woman during the period that she belonged to a man, otherwise she would be considered as committing adultery (Institute for Population 1994b: 13-14).
10. One of the two foreigners was Louis Leonowens, who gained the respect of the local people because he was a childhood friend of King Rama V. His mother, Anna Leonowens, was once the governess of the King. A rhyme about the behaviour of these foreigners and the women is said to be chanted with no embarrassment to men, women and children in the northern provinces more than 80 years later. From listening to the rhyme chanted by the local people himself, Bristowe translated it as follows:

> Dr. Chitt and Missa Louis[Louis Leonowens], sleeping with two girls, two nights for fifteen rupees. Miss Luang is on the bed. Miss On is waiting. Hurry up and finish doctor.
>
> Dr. Chitt and Missa Louis, sleeping with two girls, two nights for fifteen rupees. Miss Kum asked for silver, Miss Huan asked for cloth, Miss Noja asked for elephant. Hurry up and finish doctor.

A similar rhyme to the above written in the northern dialect is presented by Chiyaworasilpa (1964: 320).

woman who brought prostitutes from Bangkok to serve wealthy foreigners and local people in Chiang Mai. Unlike the acceptance of the earlier harem, Chiang Mai people were upset with this establishment. The prostitutes were stoned and intimidated by local people (Chiyaworasilpa, 1964: 318-319).

Despite its unpopular operation in the early years, prostitution was reported as appearing in Chiang Mai occasionally. For instance, some prostitutes appeared at the worksites of the Kuntan railway tunnel in 1910 where there were a large number of male workers (Chiyaworasilpa, 1979: 61). Some brothels were set up for the Japanese troops in Chiang Mai during the Second World War (Gehan Wijeyewardene, 1995, personal communication). According to the old people, there were very few prostitutes in Chiang Mai fifty years ago and their customers were mostly men who visited Chiang Mai from other regions (Taw, cited in Satayanurak, 1995).

Prostitution seems to have been unpopular with local men in Chiang Mai in the past. However, the establishment of Kamphaeng-din, which is the original red light district in Chiang Mai, dates back to at least thirty years ago.[11] Peasant men were inclined to visit Kamphaeng-din when they were in town for business trips as described below.

> *Aeo sao* is a male's practice since the old days. In my teens, young men aged around 15-16 years old went to Kamphaeng-din for pleasure with women. One could not frequent prostitutes at that time because of lack of transport, only bicycles or buffalo carts were available then. Thus, we often went for pleasure after a day of business trip in the city. It 's a kind of men's activity that most men, single or married, rich or poor, shy or bold would be similarly experienced in. Although it was common to get a women's disease [STD] after a visit to Kamphaeng-din, it was very easy to cure though. You only needed a shot of *Kana* injection [Kanamycin] and you were almost instantly cured.
>
> Rural village, a widower aged 59

5.3.2 Growth of Sex Industry in Chiang Mai

Although the habits of Thai men in patronising prostitutes are clearly not Western influenced (see Bamber et al., 1994; Thitsa, 1980; Boonchalaksi and Guest, 1994), it has been suggested that the blooming of prostitution in Thailand was partly initiated by the growing demand during the Vietnam war (Monklawirat and Kantavorn, 1991: 162). About 50,000 American soldiers were based in the Northeastern provinces of Thailand, and up to 70,000 combat troops visited Thailand annually on Rest and Recreation trips for fourteen years between 1962 and 1976 (Phongpaichit, 1982: 24-25). It was well known that a large demand for casual sex attracted many young women from all parts of Thailand to enter prostitution during this period (Thitsa, 1980: 15).

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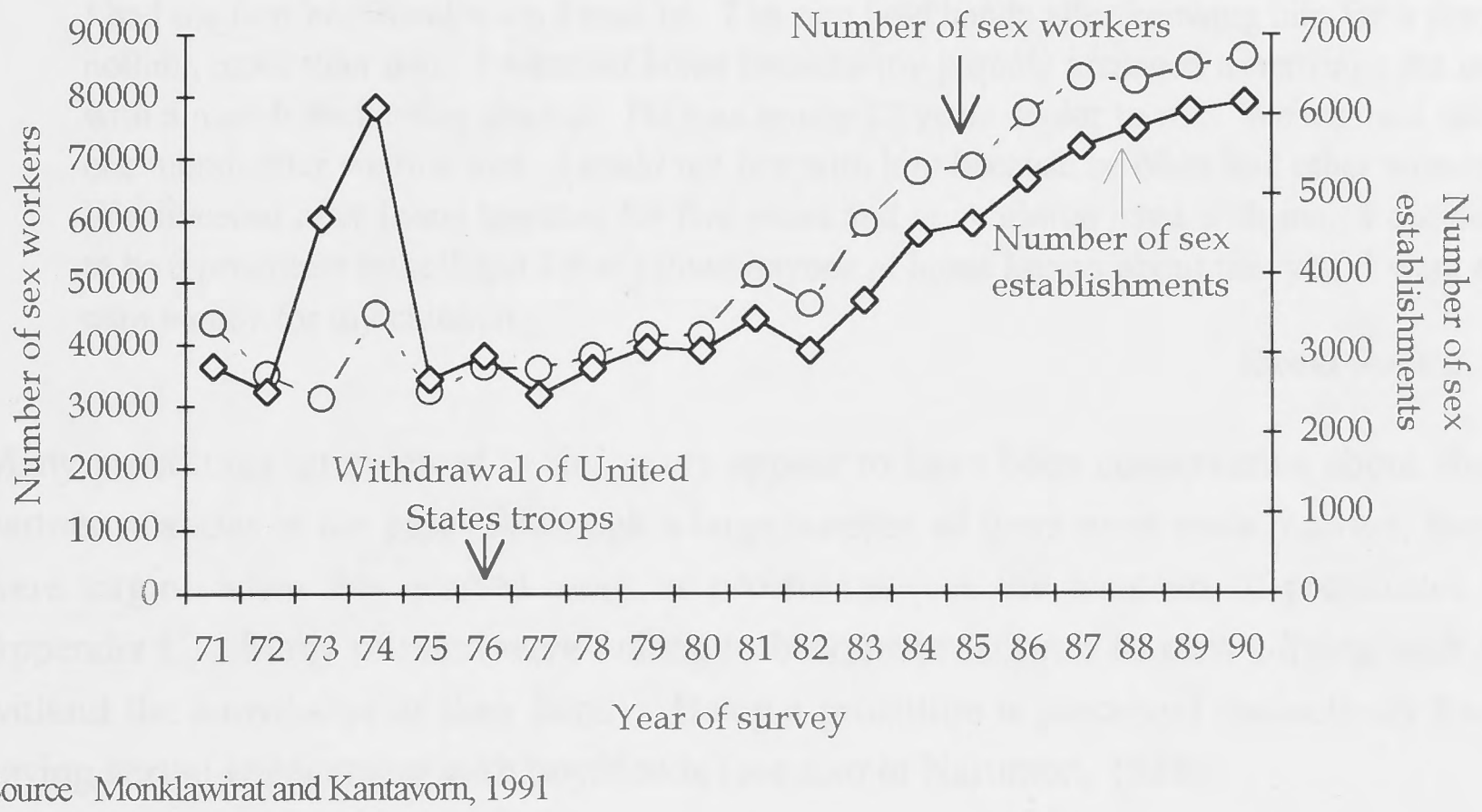
11. Gehan Wijeyewardene, who conducted an anthropological study in Chiang Mai in 1964, said that Kamphaeng-din was the only known red-light district for the local people at that time. The local customers were mostly students and tricycle drivers. He suggests that prostitution in Chiang Mai gained sudden popularity because many American soldiers visited Chiang Mai during the Vietnam War (1995, personal communication).

When the United States withdrew its forces in 1976, a large number of prostitutes were left with no income as not many Thai men could afford to pay for sex at that time. Many prostitutes moved to work in the big cities like Bangkok and Chiang Mai. The number of prostitutes increased gradually after the withdrawal of the United States troops as shown in Figure 5.1. Some authors suggested that the growing demand for prostitutes among Thai men is the consequence of the economic reform towards industrialisation in the 1970s and the promotion of tourism in the 1980s. The labour migration of rural people to the urban areas was increasing rapidly during that period (Phongpaichit, 1982; Archavanitkul, 1988; Boonchalaksi and Guest, 1994: 8-18).

Figure 5.1 Number of sex establishments and sex workers in Thailand between 1971 and 1990 [12]



Source Monklawirat and Kantavorn, 1991

5.3.3 Debts of Gratitude to Parents

The debt of gratitude to parents is a meaningful belief among Thais. The concept of *bunkhun* or the debt of gratitude was said to be the basis of kinship ties between parents and children in Thai society (Rabibhadana, 1984). By bringing them into the world, the parents earn enough gratitude to make it obligatory upon their children to support them. There are several ways for Buddhist men to repay their parents, such as to work in the farmlands, to enter monkhood and to keep the family name. The society places a greater burden on daughters by requiring them to provide financial support to parents or to earn money from marriage. For people from a poor family, to marry a wealthy man or to earn

12. Surveys of the number of brothels and prostitutes are conducted twice a year by 13 Centres for Communicable Diseases Control. This represents the count throughout the country. Despite the attempt to gain a valid count by including both direct and indirect prostitutes in the survey, the numbers are under-reported. It was proposed that there were about 200,000 prostitutes in Thailand in 1990, based on a cross-sectional survey (Sittitrai 1991) and estimation (Boonchalaksi and Guest 1994). However, the actual number of prostitutes in Thailand is unknown because of high turnover (see Appendix C for the number of times that women may re-enter prosttution).

a living by having sex with men for money may have been seen as ways in which the daughters could repay the debt of gratitude to their parents as described below by some prostitutes.

> When I was in my teens, I had about three to four boyfriends but I never let any of them commit an affair, not even holding hands. At age 16, my aunt took me to *poet borisut* ['penetrate virginity' or being sold for first sex as a virgin] with a Chinese man in his 60s. I trusted and believed my aunt because I had lived with her for several years. She told me before that she was taking me to *poet borisut* with a man. She said not to be afraid and told me to please the man well. I did not feel regret, did not think of anything because I respected my aunt so much. I don't know how much money she received, but I knew that she sent some money to my father and some was used to cover the expenses during my stay with her. I never had sex with anyone else until I met a husband at age 23.
>
> Restaurant prostitute, 36

> I had the first boyfriend when I was 16. I let him hold hands after knowing him for a year, nothing more than that. I returned home because my parents arranged a marriage for me with a man from another district. He was nearly 20 years senior to me. We married only one month after we first met. I could not live with him because he often had other women. We divorced after living together for five years and my children lived with me. I decided to be a prostitute myself and I don't think anyone at home knows about this yet. I want to earn money for my children.
>
> Brothel prostitute, 28

Many prostitutes interviewed in this study appear to have been conservative about their partner relations in the past. Although a large number of them were once married, some were virgins when they started work as prostitutes (see life histories of prostitutes in Appendix C). Many of them were willing to become prostitutes to earn a living with or without the knowledge of their family. Being a prostitute is perceived distinctively from having sexual engagement with boyfriends (see also in Narumon, 1988).

> I had the first boyfriend at age 19-20. I let him hold hands after knowing each other for a few years. He tried to have sex with me but I refused. My first sex was after marriage at age 28. My husband was from the same village. We were together for two years before marriage but the divorce took place after five years. I keep my son with me. I've just become a prostitute last year because I want to earn money for living.
>
> Brothel prostitute, 33

> I was married in my early 20s. I had first sex at age 16 after knowing my boyfriend for 5 months. Holding hands or being touched by men before marriage was common [for young women 30 years ago]. It could happen when you went to town with friends but you could not let anyone from home know though, or else you would be in trouble.
>
> Restaurant prostitute, 45

5.3.4 Ways of Becoming Prostitutes

From a review of their lives, there are several ways in which women may become prostitutes as summarised in Table 5.1 (see life-history reviews of selected prostitutes in Appendix C; Phongpaichit, 1982; Mullikamanya, 1983; Narumon, 1988; Limanonda, 1993; Hongwiwat et al., 1993a).

Table 5.1 Ways of becoming prostitutes for women

1. Single women without sexual experience who are willing to enter prostitution by themselves. They tend to have friends or relatives working as prostitutes.
2. Single women without sexual experience who are forced into prostitution by their parents.
3. Single women with sexual experience who are willing to enter prostitution.
4. Single women with sexual experience who are forced into prostitution.
5. Single and married women with or without sexual experience who are deceived into prostitution.
6. Single or married women of minority groups such as hill-tribes, or those from the neighbouring countries who are forced into prostitution.
7. Married women who become prostitutes with the knowledge of their husbands because of economic hardship.
8. Married women who are forced into prostitution by their husbands.
9. Divorced women with or without children.

In the rural village selected for participant observation, more than 20 women from this village alone had once worked as prostitutes. As told by the wife of the village head and several people in the village, none of them was forced into prostitution. They were all well accepted by the village community. Most people in the village perceived them as living a comfortable life with their Western husbands overseas. Only one former prostitute returned to live in the village and married a man from the same village. However, many people considered her a failure because of her difficult life after prostitution.

From 326 women interviewed in the survey, three currently married women reported that they were once working as prostitutes. One woman said that, because of economic hardship, she became a prostitute for a short while with the knowledge of her husband and of her own volition. The other woman was a member of hill-tribe minority who met her current husband while working as a prostitute. Before being deceived into prostitution, she was married to a man from the same hill-tribe. She was one of about 15 women who were recruited for construction work in the city by a woman from the same village but they were all later forced into prostitution. The third woman was forced into prostitution by her husband against her will.

5.3.5 Growth of Prostitution and AIDS Outbreak

Although a large number of prostitutes are women from the rural areas of the Upper-North region, these women were not initially encouraged to enter prostitution since it was contradictory to their traditional beliefs. In a collection of reports from the mass media many years ago, women from the rural areas of the Upper-North were often reported to have been forced into prostitution by their boyfriends who were mostly men from other regions. The connection of Chiang Mai to the central region by railway in 1921 was claimed to be the starting point leading the women from the Upper-North region into forced prostitution (Institute for Population, 1994b: 17-20). Those who were deceived into prostitution were not welcome back to the villages at that time. However, the money that they had earned from prostitution made them appear better off than other people in the village. They had started to repay the debt of gratitude by building a house for their parents, paying for higher education of their siblings, or donating money for temple building. As time went by, people in the villages reluctantly accepted them back into the community. A big demand for prostitution in Chiang Mai has transformed a small number of prostitutes before 1950 to more than 100 sex outlets and over 2,000 prostitutes in Chiang Mai city alone from an enumeration in January 1992 (Limanonda, 1993: 15-17). With economic hardship, an increasing number of peasant women were willing to enter prostitution following their friends and relatives (see Appendix C; Narumon, 1988: 121-122). It is known that many women in some particular villages of the Upper-North provinces work as prostitutes (Mullikamanya. 1983: 145; Institute for Population, 1994b: 21-22). Women from the Upper-North region may be in great demand for prostitution because they usually have light skin and their dialect is more softly spoken than that of women from other regions (Narumon, 1988: 188).[13]

According to some official record, women from the Northeastern region may have entered prostitution in high numbers close to or higher than those from the Northern region.[14] All American military bases were located in some Northeastern provinces during tne Vietnam war; however, the growth of prostitution did not continue substantially in these provinces after the withdrawal of the American troops in the mid 1970s. Various kinds of prostitution for local men have expanded significantly in Bangkok and some tourist provinces like Chiang Mai and Cholburi. Although prostitutes may come disproportionately from the North and the Northeastern regions,

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13. The preference for prostitutes with light skin was observed in the brothels established in Cambodia along the Thai border. Vietnamese prostitutes are more in demand than Cambodian ones because of their light skin and their feminine manners (Pramualratana 1995, personal communication).
14. From the number of prostitutes who are kept in the retention homes for occupational training, those from the Northeastern region rank first, reported at 33 to 56 per cent, followed by those from the Northern region, reported at 23 to 39 per cent from 1987 to 1991. The number of prostitutes kept in these places range between 250 and 1,100 during this period (National Statistical Office, 1992: Table 85). However, prostitutes kept at these places are direct prostitutes only. Indirect prostitutes like masseuses are never kept there as their occupation is considered legal.

the severe outbreak of AIDS in recent years is taking place in the Upper-North provinces only. The question is then why the high prevalence of AIDS is limited to the Upper-North region only.

The first part of this chapter suggests that the culture of people from the Upper-North subregion does not support premarital sex. However, changing socio-economic factors have allowed rapid development of prostitution which subsequently permit men to have sexual contact with prostitutes before union. Apart from several reasons leading Thai men to pay for sex as discussed later in Chapter 6, prostitution may be wanted by single men if they have difficulty in finding suitable non-prostitute partners. To address this issue, the next section looks at the marriage pattern of the peasants followed by discussion of a potential marriage squeeze on rural men.

5.4 MARRIAGE PATTERN AMONG PEOPLE IN THE RURAL AREAS

Many factors have contributed to the way an individual may select his or her partner. Apart from the many emotional, psychological and physical factors, other influences may include the age of partners, the marital status, the economic and education status, the availability of partners, the control of parents, the cultural expectation, and the stability of the relationship. The partnership involvement of the Thai people is culturally exceptional as it usually involves the engagement of men, their non-prostitute partners and prostitutes. As shown in Chapter 6, about 80 per cent of Thai men have had sex with prostitutes before marriage and nearly half occasionally pay for sex after marriage. Apart from sexual contact with prostitutes and non-prostitute partners, this study suggests that homogamy in marriage choice has emerged as the common marriage pattern of people in the rural areas.

From a literature review about mate selection, the common patterns of partner selection include homogamous, complementary and mixed patterns (see Epstein and Guttman, 1980). Although no single theory has been accepted as the final answer on partner selection, many studies do reveal a pattern of similarity between partners in terms of intelligence, educational attainment, personality traits and social characteristics, physical traits and physical attractiveness, age, religion and ethnic background, socio-economic status, family structure, and personal habits. Although the homogamous partnership theory has been well accepted, the assortative theory of complementarity has gained much interest as it has emerged as an alternative to the homogamous theory . It is claimed that although homogamy of social characteristics creates a field of eligibles, within this field people should choose partners whose pattern of needs is complementary to their own, to provide maximum gratification of their own pattern of needs (Winch, Ktsanes and Ktsanes, 1954).

Many husbands and wives are similar in their socio-economic and cultural characteristics because social stratification, including factors such as place of residence, type of schooling and workplace, level of education and religious beliefs, sorts them into

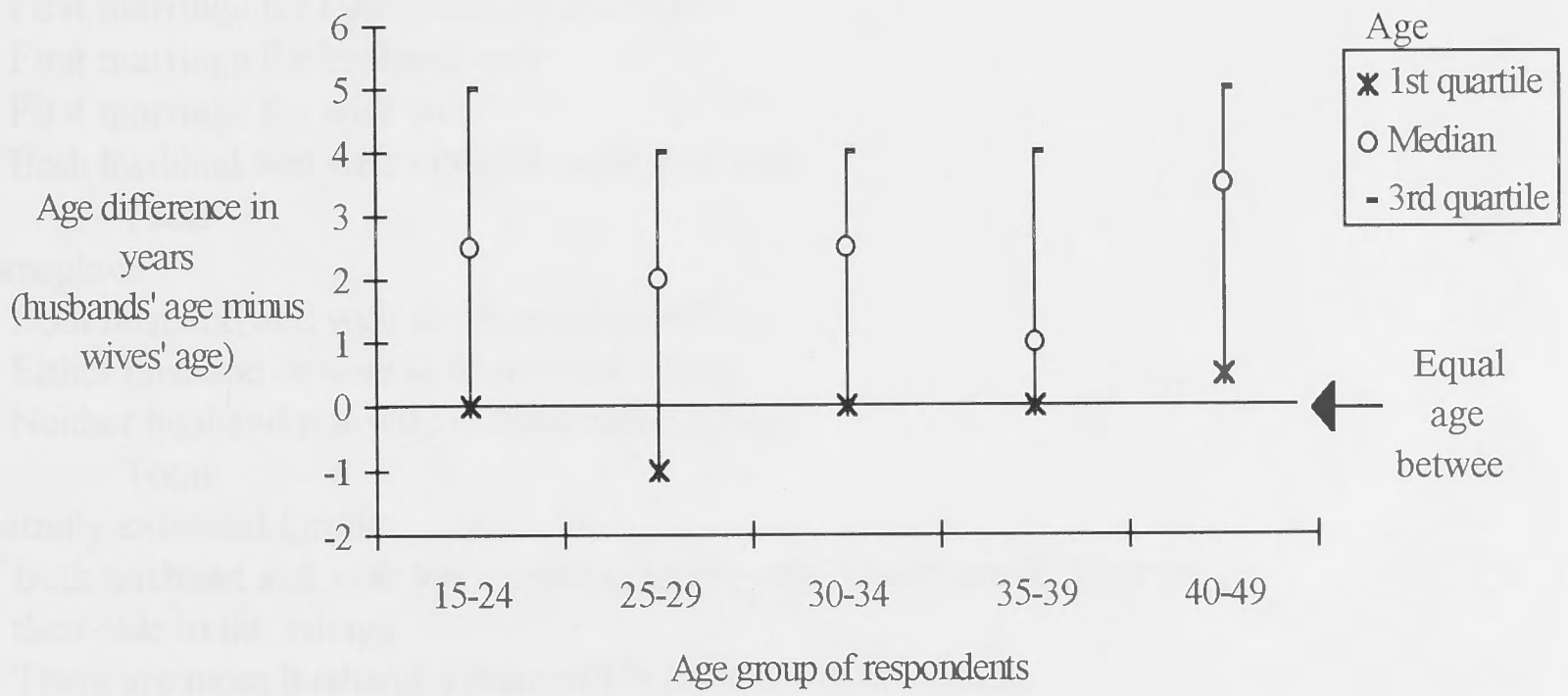
demographically separate social networks before marriage (Michael et al., 1994). The same rule applies to the people in the rural areas who are sorted by their place of residence and are, therefore, likely to meet partners who share a common background with them. In the past, young people in the rural areas usually found their spouses who came from the same village or the nearby areas and who were alike in their social class. An increasing number of them are now spending more time outside the villages so they have opportunities to meet partners who come from a different social network outside the village. However, many of them are still likely to meet persons of a similar social class.

5.4.1 Ages of Spouses

In general, a wife should be younger or not much older than her husband. In the Northern villages, conflicts in married life often arise when the wife is older, especially if a wife is 12 years older than her husband (Potter, 1977:102; Mougne, 1981: 417). However, from a random survey of a Northern village, it was found that the wife was older than her husband in one out of every seven couples (Turton, 1972: 238).

In this study, husbands are between two and three years older than their wives on average. The median age differences between husband and wife were less than four years in all age groups as shown in Figure 5.2, which is in agreement with other studies (Knodel et al., 1983: 37; Sittitrai et al., 1992: Table 3-11; Limanonda, 1994). In this figure the line plotted above the zero baseline indicates how many years husbands are older than wives by number of years presented on the Y axis and that plotted below indicates how many years husbands are younger than wives.

Figure 5.2 Median age difference of husbands and wives by age group of currently married respondents[a]



a The total number of respondents is 346. Only husband's answer was selected from 99 pairs of spouses who were both obtained for the interviews.

5.4.2 Resemblance in Socio-economic Characteristics between Spouses

Most couples were similar in their ages and selected socio-economic characteristics before marriage as shown in Table 5.1. Religion and ethnicity of the couples were excluded because most respondents were Buddhists. Regarding the economic status before marriage, it does not support a claim proposed by Brumelhuis (1993: 13) that husband-wife relationship in the Thai family is based on economic interest. Families of some wives are higher in economic status than husbands' families before marriage. However, the information presented here is limited: individuals who married for upward social status are likely to be with their spouse elsewhere so they were excluded from the survey. Regarding partner selection, young people in the rural areas usually select partners on their own with the approval of their parents before marriage (Kaufman, 1960; Limanonda, 1979, 1994; Chamratrithirong, 1983). Of 99 pairs of husbands and wives who were both interviewed, only four pairs had marriages arranged by their parents.

Table 5.2 Background characteristics of married couples [a]

Background characteristics before marriage	Per cent
Age	
Similar age between husband and wife [b]	75
Husband is more than five years older than wife	20
Wife is more than two years older than husband	5
Total	100
Education	
Not more than three years difference in years of education between husband and wife	96
Husband has more than three years of higher education than wife	3
Wife has more than three years of higher education than husband	1
Total	100
Marital status	
First marriage for both husband and wife	85
First marriage for husband only	7
First marriage for wife only	7
Both husband and wife married more than once	1
Total	100
Homeplace	
Both husband and wife are from rural village	89
Either husband or wife is from rural village	10
Neither husband nor wife is from rural village	1
Total	100
Spatially extended family	
Both husband and wife have approximately equal numbers of relatives on their side in the village	26
There are more husband's than wife's relatives in the village	34
There are more wife's than husband's relatives in the village	39
Total	100

(continue)

Economic status of wife's and husband's side before marriage [c]	
Similar status for both	61
Husband's side was higher	21
Wife's side was higher	18
Total	100

a All information, except that about economic status and spatially extended family, was obtained from 441 currently married respondents. The other two were obtained from 99 pairs of husbands and wives who were both interviewed.

b Similar age between spouses is defined as husbands not more than five years older than wives or wives not more than two years older than husbands.

c The economic status between husbands and wives was crudely estimated by asking each respondent whether they thought their or their spouse's families had higher economic status before marriage.

Post-nuptial residence is of much interest in the Thai literature. It is known that newlyweds in the rural areas of the North and the Northeast regions usually stay with the bride's parents for some time after marriage. They tend to set up a new household in the same compound as their parents' place or nearby after the birth of the first child, or after the marriage of another daughter. However, where to live after marriage is a flexible choice for the couples with no fixed rule, as pointed out by participants of group discussions, and survey data in Table 5.1. Most couples interviewed were in nuclear families containing only parents and their children. However, many nuclear families in the rural areas have the special characteristic of the 'spatially extended family', whose members lived together in the same household when they were young, and now live in separate households in the same community (Kaufman 1960: 23). Although they may live separately, the parents' and the children's families are still connected with varying degrees of subordination and dependence to the household of the parents. Therefore, the function of the household as 'the unit of emotional nucleation' (Caldwell, 1976) or 'the unit of economic maximisation' (Harbison, 1981) persists in this kind of spatially extended family. The spatially extended family is used to measure the post-nuptial residence of the couples as shown in Table 5.1.

The proportion of men and women with relatives on their side living in the same village was similar between husbands and wives. A weak position is expected for young men who live in their wife's circle of relatives who tend to report their behaviour to their wives. As suggested through group discussions, friends and relatives would keep the women informed if their husbands were having sexual affairs with any women or prostitutes. From the survey data, 26 per cent of husbands and wives had a roughly equal number of relatives on their side living in the same village.

Men in the study areas did not move to live with their wife's family after marriage. However, the prevalence of matrilocal post-nuptial residence may be under-reported because married men and women aged over 30 were over-represented in this study. Many couples tend to have already separated their own household from their parents by these ages. The prevalence of post-nuptial residence reported in Table 5.1 does not account for those who stayed with the wives' parents when they first married.

5.4.3 Different Criteria of Partner Selection between Men and Women

Although most couples in the rural areas were similar in their socio-economic characteristics, the criteria of partner selection between sexes are different. Apart from paid partners, Thai men often classify their girlfriends into those for casual relations and those for family formation. Many of them expressed concerns through group discussions about whether the women that they expected to marry were virgins.

Headman: To be frank like men talk to men, what do you consider when you marry a women?
1st man: First, whether she is a young virgin or not. Secondly, whether she has flirted around with other men before or not.
2nd man: How can you be sure about that now?
1st man: How could you say? Don't you be selective once you have a wife? Won't you find out whether she has slept around? How about if she used to be a prostitute and brings you a women's disease [STD]. How embarrassed would your family be?
2nd man: You must check her background. Where was she born, and what is she like when grown up [by observing or asking from other people]?
Headman: We are men, and we don't want a woman who has passed through the hands of other men before.
1st man: When you want to have a wife, of course, you want a virgin, right? Not a woman that you don't know her background. It is a shame for you and your children. What a shame if your wife slept around before.

Urban village, married men

Headman: What kind of woman will men choose to marry?
1st man: Good person, tidy...what else...do not have AIDS of course.
Headman: What are the good qualifications of a wife then?
2nd man: Carefully look after house tasks. Wash clothes, clean dishes for us. Prepare food for us. Go farming together with us. We are the elephant's front legs, not the hind ones, right? We lead and they follow.
3rd man: Easy to communicate. Understand and compromise.
2nd man: Choose the good person - the one you know her background.
4th man: The one you can be sure that she is a virgin who has never engaged with other men before.
5th man: Even if she is not a virgin, do not mention it to the husband because the man will be offended.

Rural village, married men

Contrary to men, women cited hard work and affection when selecting a husband. Some said the economic stability of the husband's family was an advantage. However, the economic status of husbands and wives before marriage was not significantly different as shown earlier.

1st wom: Choose the one who loves you. A good person who can adequately look after you [everyone agrees].
Moderator: Do you mean that the man should be wealthy?
1st wom: Yes, he should be a little bit well off otherwise we both have to eat salt when living together.
Moderator: I guess it may be hard to tell whether a man is a good person or not. All

seem to be good when we first met.

2nd wom : It takes time. You need to study each other for some time.

Moderator: For how long though?

1st wom: Three weeks in my case....(laughs).....He asked me to marry him and I agreed.

Urban village, married women

1st wom: Choose the man with a good nature. It is not necessary that he is rich or good-looking but he must be a hard worker so we can help each other to earn livings.

2nd wom: He should not be easily upset.

Moderator: How about if he enjoys drinking?

Several wom: That is okay on special occasions, but not if he drinks every day.

2nd wom: It is not a problem now when men drink because women also drink too. They both enjoy and get drunk afterward.

Moderator: How about if he is a womaniser?

3rd wom: I do not mind as long as his heart is always with me.

Rural village, married women

Table 5.2 shows that the respondents of both sexes highly valued the attitude that women should be virgins at marriage. Nevertheless, men seemed to be less conservative than women in their views about women's virginity and not all men perceived it as important. Only 49 per cent of single men with sexual experience and 55 per cent of currently married men said that it was necessary for their wives to be virgins when they married. Some men did not object to marrying women who used to work as prostitutes (see case study number 6 of Appendix C; Mougne, 1981: 436; Hongwiwat et al., 1993a, 1993b). A number of men believed that very few women in the younger generation were able to keep their virginity until marriage, but not because they thought that women's virginity was unimportant.

Moderator: Do you think women these days are still virgins when they are married?

1st man: It used to be like that in the past but this has changed now.

2nd man: In the past, men would only marry virgins.

3rd man: Young women in this generation are no longer virgins by the time they are married. I would say only 1 or 2 out of ten may be.

1st man: Hey, but we were not virgins at marriage .....(laughs).....

2nd man: When I was married in 1962, 100 per cent of women in that generation were still virgins at marriage. The rising number of single women with sexual experience only happens in the past few years when young people have started to have sexual engagement among themselves.

3rd man: It started in 1974 when the discotheque was first introduced to Chiang Mai. The children started to misbehave then.

Rural village, married men

Table 5.3 Per cent distribution according to attitudes about women's virginity before marriage

Statements	Agree	Not sure	Disagree	Total %	N
A woman should be virgin until marriage.					
Women	94	2	4	100	326
Men	69	10	21	100	293
A woman should marry the man to whom she has lost her virginity.					
Women	71	13	16	100	326
Men	50	18	32	100	293

5.5 POTENTIAL MARRIAGE SQUEEZE ON BACHELORS IN CHIANG MAI

The division of social classes according to education, occupation, place of residence and economic status has limited the choice in partner selection for many people, especially among those coming from the rural areas. Prostitute patronage is mostly perceived to be a common culture of Thai men from all levels which is facilitated by peer groups and social drinking. However, this study adds that the lack of potential partners for single men cannot be overlooked as it adds to the reasons why a large number of men seek casual sex with prostitutes while single (Chapter 6 shows sexual contact of men with prostitutes before and after marriage). To address this issue, the sex ratio of single men and women is calculated to detect potential marriage squeeze.

5.5.1 Review of Marriage Squeeze

The sex imbalance in the number of single men and women is known in demographic literature as a 'marriage squeeze', and has been of concern for over thirty years. The imbalance between the sexes may result in a great surplus of men or women of marriageable ages which means that a significant number of them will have difficulty in finding a spouse. These unbalanced marriage markets are common and generally work to the detriment of women because of social norms that brides should be younger than grooms (Akers, 1967; Muhsam, 1974; Weeks, 1978; Schoen, 1983; Zopf, 1984; Veevers, 1988; Goodkind, 1994).

Migration, fertility and mortality factors have all contributed to the inequalities in the sex ratio which is the number of men per 100 women in a population. Statistics have shown that the sex ratio at birth is a biologically stable number of around 106 male births per 100 female births in normal circumstances. The sex ratios decline by advanced ages because of the higher mortality of men than women. Some single women who were born during the baby boom period are squeezed out of the marriage market because there are

not enough potential husbands who are a few years older than themselves. On the other hand, for those who were born during a substantial decline in the birth rate, it would be the young men who would be caught in a marriage squeeze (Schoen, 1983; Zopf, 1984; Zeng et al., 1992; Veevers, 1988).

Developed and less developed countries have experienced different types of marriage squeeze: the squeeze affects men in the former, and women in the latter. In Germany, the excess of single males at younger marriageable ages has resulted from the fact that more men than women are born and there is a strong preference for a partner of the same age, with the bride a little younger than the groom (Pollard and Hohn, 1993). In sub-Saharan Africa and South Asian countries like Bangladesh, large surpluses of women are created primarily by the very large age differences at marriage and the fact that widows can remarry. However, the potentially large surplus in these high-fertility countries is reduced by the fact that female mortality exceeds male mortality (Goldman and Pebley, 1989). China provides a good example of the distortion of the male surplus because of son preference among the Chinese which in turn will have a direct effect on marriage. In about 20 years, there will be 1.2 million Chinese men each year who will not be able to find a woman to marry (*China Population Review*, 1992; Zeng et al., 1992). A similar male surplus occurred in Australia in 1840, as a result of a sexually unbalanced migration stream, so that a large number of single women in the British Isles were sent out to Australia to provide a better balance in the marriage market (McDonald, 1995: 2). In Vietnam, a unique double marriage squeeze phenomenon has occurred as a combination of rapid population growth, excess male migration and mortality in the wars which has led to the great shortage of men at primary marriageable ages. In contrast, young Vietnamese males residing abroad face an even stronger deficit of Vietnamese women. The consequences for overseas men have included delayed marriage and increasing tendency to marry a non-Vietnamese (Goodkind, 1994).

In Thailand, the marriage squeeze phenomenon has gained little attention even though the high prevalence of rural-to-urban migration and the remarkable fertility decline over the past two decades probably led to the surplus of young men over women left in the rural areas. As suggested in Chapter 1, the increased access of women to higher education and the increased migration of young women to the urban areas are believed to be the contributing factors to delayed marriage for rural men and women. The availability of women for men in the rural areas is reduced when women decide to remain single which subsequently leads to increased celibacy of men. The rapid fertility decline during the 1970s and 1980s probably has started to limit the potential marriage partners for men at the present time as more boys than girls are born and there is a preference for husbands to be only a few years older than wives.

The marriage squeeze has not been perceived to be an important factor leading to increased celibacy for Thai men (Guest and Tan, 1994). Instead, male celibacy has not changed between the 1970s and the 1990s; therefore, it was concluded that there has

been an ample supply of eligible women for Thai men. However, if the population composition is stratified by sex and rural-urban residence, the surplus of men is expected to be substantial, especially in the rural areas of Chiang Mai for three main reasons: first, fertility in Chiang Mai started falling earlier than in the rest of the country, therefore, young men in Chiang Mai who were born twenty years ago probably have a smaller pool of women who are only a few years younger; second, women in the Northern region outnumbered men in migration for modern sector employment, thus fewer bachelors were left in the rural areas; and lastly, an increasing number of women are now having higher education like men but this has limited the number of eligible partners for both sexes because men usually marry women who have the same or a lower level of education. It is likely that the more educated the women are, the more they will delay their marriage.

The small age difference between spouses as shown in Table 5.2 means that overall there is unlikely to be a significant squeeze at a national level. However, people frequently change their place of residence, thus the surplus of single men or women in any particular areas would be subsequently adjusted. The unbalanced sex ratio of single people by areas deserves special attention since their selection of partners may be limited from the division of social class causing by rural and urban residence. In a society like Thailand where the division of social classes is evident, the search for suitable partners is beyond the issue whether or not the aggregate numbers of single men and women are balanced. As suggested earlier, men and women are looking for those who share similar socio-economic characteristics to themselves at least in regard to their education and economic background. Social class among Thais is clearly divided by rural and urban residence; those from the rural areas are the poor with low education. Many of them migrate to town for better jobs but they are still considered the urban poor. If there is a surplus of single men or women in the rural areas, the division of social class would prevent some of them from successfully finding suitable partners when they move to the city. Some of them may find partners while working in town but some may have difficulty finding partners as migrants. Some may prefer partners from the same region who share a similar socio-cultural background. The high levels of migration may unbalance sex ratios at the local levels, also provides the opportunity for courting behaviour to take place over a longer distances. In addition, cultural and social practices underlying mate selection need to be adjusted to changes in availability of spouses. Whether or not single migrants select partners while they work in town, or return home for partner selection, needs an investigation.

5.5.2 Sex Ratio Method of Measuring the Marriage Squeeze

There is no direct way to measure the marriage squeeze. The standard measurements of the marriage market are based on the hypothetical assumptions that there is no in- or out-migration, everyone wants to marry a person of the opposite sex and there are no remarriages (Veevers, 1988; Goldman and Pebley, 1984). The implications of moving

away from these hypothetical assumptions are included in later discussion. The simplest and most common way to measure the marriage market has been by calculating the ratios of the number of single men to women at the prime marriageable ages. However, the probabilities of marriage at lower-limit ages should be as nearly equal as possible because those eligible to marry are concentrated heavily at younger ages. The changes in marrying ages through time should be noted (Carmichael, 1982: 259).

Three methods were adopted here to calculate the sex ratios: the sex ratios of single men and women in the same five-year age group (Veevers, 1988: Table 2; Goodkind, 1994); the sex ratios of single men five years older than women in the same age group (Jones, 1994: Table 4.1); and the sex ratios of the ten-year age range of men and women at the prime marrying ages (Carmichael, 1982: 260-262). The published Thai census data are limited and give numbers of single populations in five-year age ranges only. By assuming that the number of single people is evenly distributed throughout the five-year age group, the single-year population was estimated by dividing by five the numbers of single people in a five-year age group. The strategy adopted allowed the measurement of sex-ratios by the last method which gives the proxy marriageable ages based on the single-year data.

The sex ratios measured by the first and the second methods were highly distorted: over-estimated for the former and underestimated for the latter as shown in Table 5.3. The use of five-year age group data without any adjustment probably caused these severe distortions. According to the single-year calculation, the results are summarised as follows: bachelors outnumbered spinsters in the rural areas of Chiang Mai in 1960 and 1990, and in Bangkok in 1960 and 1980; spinsters outnumbered bachelors in the rest of the selected areas including urban and rural areas of the whole kingdom throughout the period 1960 to 1990, in the rural areas of Chiang Mai in 1970 and 1980, and in Bangkok in 1970 and 1980.

The fluctuation of sex ratios as shown in Table 5.4 probably has resulted from the interactions of four main factors: mortality, fertility, migration and increased age at marriage of men and women. Also, it indicates that the quality of underlying data needs to be assessed. Women are expected to outnumber men in general because men have a higher mortality rate from the risk involved in their work and activities. The improved health status of pregnant women has maintained low mortality among Thai women. However, the rapid fertility decline probably increases the number of newborn males, and this phenomenon is expected to be taking place early in Chiang Mai because fertility in this province declined earlier than in the rest of the country (see a review in Chapter 1). Therefore, if men still prefer to marry women who are only a few years younger than themselves, it is expected that single men at marriageable ages in Chiang Mai will outnumber single women at marriageable ages from 1990 onward. However, migration is important in explaining the imbalance of sex ratios. The surplus of bachelors in the rural areas of Chiang Mai became evident in 1990 because women in the areas outnumbered men in migration for modern-sector employment. In Bangkok, labour

migration of both sexes is in large demand with a shift of male or female-dominated migration in each census round. The surplus of bachelors in the 1980s probably reflects the need for labour migrants for expansive constructions in Bangkok. Both female-dominated migration and increased celibacy among women in Bangkok have contributed to the surplus of spinsters in Bangkok at the present time. The rate of HIV infection in the Northern area is extremely high: whether or not Northern men frequent prostitutes more than men in other areas both in terms of prevalence and coital frequency needs a specific study, including the study of the factors such as fertility, migration, age at marriage and availability of partners.

The marriage squeeze presented here is crudely estimated. In the real situations, people often move in and out of their living areas, some remain unmarried and some do marry partners of very different ages. An appropriate availability index needs to be constructed for the estimation of the marriage squeeze including factors such as the age range of eligibles; the number of potential brides including widows; cohabitation; and homosexuality (Veevers, 1988; Goldman and Pebley, 1984). Nevertheless, the high sex ratios of single populations in the rural areas of Chiang Mai support the early observation that there is a surplus of men there.

5.5.3 Sex Ratios by Educational Attainment

The higher level of education is another factor leading to a marriage squeeze. The imbalance of Thai men and women in educational attainment has been suggested before with limited information (Limanonda, 1992; Jones, 1995; see also Chapter 1). Men tend to marry down, if not with equals, and women correspondingly marry up with respect to education. Therefore, an appropriate measurement for the marriage squeeze would be a comparison in the numbers of single men who are a few years older with a similar or higher education. However, the following measurement for rural populations is limited because people with higher education usually migrate to towns for suitable employment. Only those with the minimum compulsory education are left in the villages so the couples in the rural areas tend to be similar in their educational background.

Data from the 1990 census data show that the surplus of women with university education was rising in all selected areas when the sex ratio was stratified by educational attainment as shown in Table 5.4. In contrast, the surplus of men with vocational college diplomas was substantial, particularly in the rural areas. This imbalance of sex ratios between university educated men and women suggests that a number of women with university degrees may not be able to find partners with a similar educational background. This indicates the surpluses of young, less-educated bachelors, and of older more-educated spinsters. It is likely that the number of single women is rising because of their increased levels of education and employment opportunities. The lack of knowledge in the area suggests an urgent need for research.

Table 5.4 Sex ratios of single men and women at marriageable ages using Thai census data from 1960 to 1990

Areas by years	Sex ratios of bachelors to spinsters by specific ages							
	Same age group for bachelors and spinsters (Five-year age range)		Bachelors five years older than spinsters (Five-year age range)			Bachelors three years older than spinsters (Ten-year age range)		
	M 20-24 F 20-24	M 25-29 F 25-29	M 20-24 F 15-19	M 25-29 F 20-24	M 30-34 F 25-29	M 19-28 F 16-25	M 20-29 F 17-26	M 21-30 F 18-27
Chiang Mai - rural area								
1960	235	266	104	105	97	127	135	140
1970	189	245	49	65	143	79	74	83
1980	170	178	74	53	61	81	89	80
1990	180	202	100	109	108	121	126	129
Whole kingdom - rural areas								
1960	167	175	73	55	53	90	89	91
1970	168	151	51	49	57	76	69	74
1980	156	127	59	43	39	79	73	75
1990	160	147	76	65	57	94	92	94
Bangkok								
1960	167	187	111	73	66	113	117	115
1670	127	127	70	51	54	80	79	68
1980	115	109	85	52	37	133	139	144
1990	102	107	93	65	51	87	88	83

Table 5.4 (Continued)

Areas by years	Sex ratios of bachelors to spinsters by specific ages							
	Same age group for bachelors and spinsters (Five-year age range)		Bachelors five years older than spinsters (Five-year age range)			Bachelors three years older than spinsters (Ten-year age range)		
	M 20-24 F 20-24	M 25-29 F 25-29	M 20-24 F 15-19	M 25-29 F 20-24	M 30-34 F 25-29	M 19-28 F16-25	M 20-29 F 17-26	M 21-30 F 18-27
Chiang Mai - urban area								
1960	a	a	a	a	a	a	a	a
1970	a	a	a	a	a	a	a	a
1980	125	109	94	49	35	87	88	85
1990	98	107	89	55	63	82	82	80
Whole kingdom - urban areas								
1960	a	a	a	a	a	a	a	a
1970	126	134	64	54	57	79	77	79
1980	120	111	81	52	37	84	83	81
1990	105	110	86	66	52	86	86	84

a The census figures do not distinguish between urban and rural populations.

b The census enumeration for 1960 and 1970 separated Phra Nakhon and Thonburi provinces but both were included and enumerated as Krungthep or Bangkok province starting from 1980. The figures of the 1960 and 1970 censuses represent Phra Nakhon province only.

Note: The sex ratio is less than 100 suggesting that there is a surplus of single women. The ratios are rounded to nearest number.

Table 5.5 Age-specific sex ratios of single populations aged 15 to 34 by area and level of education completed from 1990 census

Areas by age groups	No education		Primary school		Secondary school		Vocational college		University	
	sex ratio	%male - %female	sex ratio	% male- %female	Sex ratio	% male- % female	Sex ratio	%male- %female	Sex ratio	% male- %female
Chiang Mai - rural area										
15-19	75	43-57	102	50-50	108	52-48	130	57-43	78	44-56
20-24	77	44-56	101	50-50	150	60-40	158	61-39	88	47-53
25-29	84	46-54	100	50-50	162	62-38	143	59-41	93	48-52
30-34	87	47-53	100	50-50	185	65-35	134	57-43	102	50-50
Chiang Mai - urban area										
15-19	71	42-58	82	45-55	92	48-52	136	58-42	68	40-60
20-24	93	48-52	92	48-52	95	49-51	97	49-51	77	44-56
25-29	116	54-46	79	44-56	109	52-48	93	48-52	74	43-57
30-34	73	42-58	75	43-57	116	54-46	119	54-46	90	47-53
Bangkok										
15-19	72	42-58	69	41-59	100	50-50	96	49-51	76	43-57
20-24	77	44-56	78	44-56	107	52-48	96	49-51	84	46-54
25-29	50	33-77	78	44-56	115	53-47	94	48-52	88	47-53
30-34	40	29-71	75	43-57	125	55-45	103	51-49	98	49-51

Table 5.5 (continued)

Areas by age groups	No education		Primary school		Secondary school		Vocational college		University	
	sex ratio	%male - %female	sex ratio	% male-%female	Sex ratio	% male-% female	Sex ratio	%male-%female	Sex ratio	% male-%female
Whole kingdom-urban area										
15-19	75	43-57	74	43-57	100	50-50	105	51-49	74	42-58
20-24	64	39-61	80	44-56	109	52-48	104	51-49	80	44-56
25-29	57	36-67	78	44-56	117	54-46	97	49-51	83	45-55
30-34	47	32-68	74	43-57	130	57-43	110	52-48	94	48-52
Whole kingdom-rural area										
15-19	79	44-56	99	50-50	117	54-44	136	58-42	74	42-58
20-24	58	37-63	95	49-51	153	60-40	155	61-39	80	44-56
25-29	63	39-61	91	48-52	177	64-36	145	59-41	88	47-53
30-34	58	37-63	90	47-53	218	69-31	169	63-37	107	52-48

5.6 DISCUSSION

This chapter has shown that the partnership development of *khon muang* or those from the Upper-North region was once restricted since it was controlled by people's beliefs about the effect of the spirits. Such beliefs kept the prevalence of premarital sex low in the past. It seems that the current outbreak of AIDS in the Upper-North region would not have occurred if the HIV virus has emerged during the time when premarital and extramarital sex were disapproved by the supernatural powers. However, the spiritual beliefs that controlled sexual behaviour in the past had limitations. The locus of this spiritual control was on women only since its primary function was to protect single women from getting pregnant which would bring disgrace to their family; men were not harmed by the spirits for premarital sex, because the spirits, or in fact the disapproval by the women's parents, could not work through them. Therefore, men are free to have sexual relations with women like prostitutes or those who are less likely to be harmed when they have sexual relations with them. Chapter 6 discusses the type of women that men may have sexual relations with in detail.

The presence of a harem in Chiang Mai during the time when prostitution was supposed to be prohibited suggests an exception that single women who engage in sexual relations would not be punished by their parents or be condemned by the community. This attitude has promoted the growth of prostitution in Chiang Mai which has developed rapidly in a short time, in comparison to the lengthy development of prostitution in Central Thailand. The recent growth of prostitution has made it easy for local men to frequent prostitutes into various kinds. Traditional courtship and beliefs about the effect of the spirits on partner relations are largely disappearing now that an increasing number of young people move out of the villages for urban employment or for higher education in the city. These young people are moving away form their cultural support systems of families and communities. They are exposed to beliefs and culture which are different from what their parents once followed. In addition to all the above factors, the lack of control by parents probably gives freedom to young men to engage in premarital sex, and particularly for single men to pay for sex.

People in the village find partners who are similar to themselves in socio-economic background. However, several factors, including increased rural-to-urban migration and higher education of women, have led to a potential unbalanced marriage market in Thailand. From the division of social classes by economic status and education, a number of rural men would have difficulty in finding suitable partners for marriage. Consequently, the lack of a wife or stable partner has predisposed them to pay for sex. The expectation of men to marry virgin women would further limit their choice in partner selection. It is likely that a number of young men in the rural areas or those of low socio-economic status may be pressed to delay their marriage, to remain single, or to marry women who may be less preferable, such as former prostitutes, or women with

sexual experience. Whether or not rural men have difficulty in finding suitable partners needs a specific investigation.

The importance of women's virginity explains why men seek sexual experience with prostitutes or non-prostitute girlfriends before marriage but yet prefer to marry or to live with women who have never had sexual experience. Prostitution has provided an alternative for single men enabling them to have premarital sex. however, the basic reason that Thai men pay for sex is beyond the traditional concern that women should preserve their virginity until marriage, and this issue is explored in Chapter 6.

CHAPTER 6

Sexual Contact before and after Marriage

The recent outbreak of AIDS with a major heterosexual transmission component in Thailand has suggested that a large number of men have unprotected sex with multiple partners. This chapter seeks reasons why men have developed their liaisons with prostitutes or non-prostitute partners apart from their relationships with wives or steady girlfriends. The types of sex partners of men and women in their lifetimes are compared. The prevalence and the frequency of visits to prostitutes by single and married men in their lifetime are given including their reasons for prostitute patronage. Sexual relations within marriage are explored to find reasons why some married men seek casual sex with women other than their wives after marriage. This chapter explores heterosexual contact before and after marriage in three major themes: prevalence of sexual contact before and after marriage, reasons for prostitute patronage before and after marriage, and sexual relations within marriage.

6.1 SEX PARTNERS OF MEN AND WOMEN

The survey of this study includes 619 men and women aged 15 to 49 years. When distributed into the type of sex partners that they have had in a lifetime, men and women are distinctive in their sexual contacts with the opposite sex. While most women have had sexual intercourse with only their husbands, many men have prostitutes and women other than wives as their sex partners. As shown in Table 6.1, while 37 per cent of single men said they had had sexual intercourse with girlfriends, only four per cent of single women said they had had sexual intercourse with boyfriends. Less than one per cent of women reported having ever had sex with men other than their husbands before marriage. The following explains why reports about the sexual engagement between men and women are inconsistent. First, single women with sexual experience may not tell the truth because the society disapproves of premarital sex as discussed in Chapter 5. Only one currently married woman said that she had sexual relations with her husband before marriage. One of the two single women with sexual experience said she had sexual intercourse with her future husband as the wedding date was soon. Secondly, the survey probably excludes a number of single women with sexual experience who were away from home for work or education-related reasons. About one-third of the single women interviewed for the survey were secondary or high school students aged below 20. As suggested in Chapter 5, students with sexual experience are likely to be in tertiary education; however, these students are mostly excluded from the survey because they live in the city. Thirdly, on one hand, there may be only a small pool of single women who have had sexual relations with several men. On the other hand, single men with sexual experience may have had sexual relations with married women or widows, not single women.

Table 6.1 Lifetime sex partners of men and women by marital status

Single men (N=85)		**Ever-married men (n=206)** [a]	
Never had sexual intercourse	31	Had intercourse with wife only	8
Had sexual intercourse with non-prostitute women only	8	Apart from wife, had sex with non-prostitute women	11
Had sexual intercourse with prostitutes only	32	Apart from wife, had sex with prostitutes	46
Had sexual intercourse with both prostitutes and non-prostitutes	29	Apart from wife, had sex with both prostitutes and non-prostitutes women	35
TOTAL	100	TOTAL	100
Ever had sex with prostitutes[b]	*61*	*Apart from wife, ever had sex with prostitutes* [b]	*81*
Ever had sex with non-prostitutes[b]	*37*	*Apart from wife, ever had sex with non-prostitutes* [b]	*46*
Single women (N=57)		**Ever married women (N=269)**	
Never had sexual intercourse	96	Had intercourse with husbands only	99
Ever had sexual intercourse with boyfriends	4	Ever had intercourse with men other than husbands before marriage	1
TOTAL	100	TOTAL	100

[a] Missing cases=2

[b] The sum is not equal to 100 because some men have sex with both prostitutes and non-prostitute women.

In addition to Table 6.1, only 12 per cent of single men with sexual experience had had sex with girlfriends exclusively from prostitutes. The rest had had prostitutes as their sex partners and about half had also had intercourse with non-prostitute girlfriends.

6.2 PROSTITUTE PATRONAGE BY MARRIED MEN

The type of partners for ever married men at the period before and after marriage is stratified in Table 6.2. Before marriage, 18 per cent of ever married men were virgins, 77 per cent had had sex with prostitutes, and 35 per cent had had sex with non-prostitute women. After marriage, about 57 per cent of them did not have sexual intercourse with any women other than wives. However, apart from wives about 40 per cent of them had had sex with prostitutes and eight per cent had sex with non-prostitute women.

Table 6.2 Per cent distribution according to lifetime sex partners of ever-married men at the period before and after marriage

Sexual contact before and after marriage	%	N
BEFORE MARRIAGE		
Never had sexual intercourse with any women	18	37
Had sexual intercourse with non-prostitute partners only	5	10
Had sexual intercourse with prostitutes only	47	96
Had sexual intercourse with both non-prostitutes and prostitutes	30	63
TOTAL	100	206 [a]
Had sex with prostitutes [b]	*77*	*159*
Had sex with non-prostitutes [b]	*35*	*73*
AFTER MARRIAGE		
Never had sexual intercourse with any women other than wife	57	116
Apart from wife, had sexual intercourse with non-prostitutes only	5	10
Apart from wife, had intercourse with prostitutes only	35	73
Apart from wife, had sexual intercourse with both prostitutes and non-prostitutes	3	7
TOTAL	100	206
Had sex with prostitutes [c]	*40*	*80*
Had sex with non-prostitutes [c]	*8*	*17*

a Missing cases=2
b The sum is not equal to 100 because some men have had sex with both non-prostitute partner and prostitutes before marriage.
c The sum is not equal to 100 because some men do not have sex with women other than wife after marriage.

The figures reported in Table 6.2 are invalid for a few reasons. 'Ever-married men' here refers to three groups of men: currently married men in their first marriage (n=170), currently married men who have married more than once (n=24), and those who are divorced, separated or widowed (n=14). While this information indicates the type of sex partners before and after marriage, it does not verify when the sexual contact with women other than wives occurred. With no current partners, men who were divorced, separated, or widowed are likely to have some casual partners. Similarly, men who are

in their second marriage and over may have had relationships with women other than wives during the time when they separated from a previous wife but had not married the next wife. Therefore, the information from currently married men who are in their first marriage would give a more valid picture about the type of sex partners of married men. However, when we exclude men in their second marriage and over and those who were divorced, separated or widowed, the proportions of men according to the type of their sex partners at the time before and after marriage have not changed as shown in Table 6.3.

Table 6.3 Per cent distribution according to lifetime sex partners of currently married men in their first marriage at the period before and after marriage

Sexual contact before and after marriage	%	N
BEFORE MARRIAGE		
Never had sexual intercourse with any women	19	32
Had sexual intercourse with non-prostitute partners only	4	7
Had sexual intercourse with prostitutes only	48	81
Had sexual intercourse with both non-prostitutes and prostitutes	29	48
TOTAL	100	168 [a]
Had sex with prostitutes [b]	*77*	*129*
Had sex with non-prostitutes [b]	*33*	*55*
AFTER MARRIAGE		
Never had sexual intercourse with any women except wife	57	96
Apart from wife, had sexual intercourse with non-prostitutes only	3	5
Apart from wife, had intercourse with prostitutes only	36	60
Apart from wife, had sexual intercourse with both prostitutes and non-prostitutes	4	7
TOTAL	100	168 [a]
Had sex with prostitutes [c]	*40*	*67*
Had sex with non-prostitutes [c]	*7*	*12*

[a] Missing cases=2
[b] The sum is not equal to 100 because some men have had sex with both non-prostitute partner and prostitutes before marriage.
[c] The sum is not equal to 100 because some men do not have sex with women other than wife after marriage.

It can be concluded that before marriage about 80 per cent of men who are currently married had ever had sex with prostitutes and about 35 per cent of them had had sex with women other than their current wife. After marriage, about 40 per cent of currently married men had had sex with prostitutes apart from wives and nearly 10 per cent had had sex with non-prostitute women.

The sexual behaviour of currently married men during the periods before and after marriage is distinctive. While half did not have sex with women other than wives after marriage, nearly half had had sex with prostitutes and a small number had had sexual engagement with other women. Table 6.4 shows the distribution of sexual contact before and after marriage of currently married men to show how their sexual behaviour had changed once they were married. Men who had ever paid for sex before marriage were most likely to be those who continued to pay for sex once they were married. Twelve per cent of married men had had sexual experience with prostitutes only after they were married. However, this group of men were married when they were as young as 18 on average. About half of married men who had paid for sex before marriage had ceased their casual sex contact with prostitutes after marriage. The survey data were consistent with the reports from male group discussions:

1st man: All of us are married now so we should not be promiscuous by going *aeo sao* because we have wives.
2nd man: Not even once after marriage in my case.
1st man: Not only once but a few times, maybe. Am I right?...(laughs)
3rd man: I have been married for 14 years. I went *aeo sao* only five times after marriage, and all the visits were during the first five years of my 14 year marriage.

Urban village, married men

1st man: Men won't go *aeo sao* if they have a family.
2nd man: Is that true?
1st man: Of course, this is how you feel once you have a family especially when you have children to look after. You no longer feel like paying for your own pleasure. This has changed from what we used to be when single.
Moderator: But I think some married men still go *aeo sao* after marriage?
1st&2nd man: Probably 10% still do because they have family conflicts.
3rd man: Single men frequent prostitutes more than married men because they don't have any family burden. Those who are married do not have much chance to be socialised except when there is a village fair for example that they may have an excuse to be away from home. The married men who are not faithful to their wives probably go to brothels. Some men go *aeo sao* again when they turn 40 or 50 because their children are all grown up and they have more money to spend by this age. Other than that, women become less interested in sex by middle age too.

Rural village, married men

Headman: Who have the highest chance of getting AIDS?
1st man: Those who frequent prostitutes.
2nd man: How could you say that? Who hasn't had sex with prostitutes? We all did.
Headman: Do men have sex with prostitutes once they are married?
3rd man: Probably not.
4th man: In principle, all are afraid of getting AIDS now [from having sex with prostitutes] but it is uncontrollable once they are drunk or are persuaded by friends. Since AIDS comes 4-5 years ago, I never sleep with any one else [beside my wife].
Headman: Who frequent prostitutes more often between single and married men?
5th man: Married men because young men are highly educated now.
6th man: Those aged in their 30s or nearly 40 frequent prostitutes most.

Urban village, married men

Table 6.4 Per cent distribution according to sexual contact before and after marriage of currently married men at first marriage

SEXUAL CONTACT AFTER MARRIAGE	SEXUAL CONTACT BEFORE MARRIAGE
1. 57% of currently married men had sex with wives only after marriage (N=96)	24% never had sexual intercourse 7 % had sex with non-prostitute women 42% had sex with prostitutes 27% had sex with both prostitutes and non-prostitute women *A total of 69% had had sex with prostitutes* *A total of 34% had had sex with non-prostitute women*
2. Apart from wives, 40% of currently married men had sex with prostitutes (N=67)	8% never had sexual intercourse 0 % had sex with non-prostitute women 61% had sex with prostitutes 31% had sex with both prostitutes and non-prostitute women *A total of 92% had had sex with prostitutes* *A total of 31% had had sex with non-prostitute women*
3. Apart from wives, 7% of currently married men had sex with non-prostitute women (N=12)	42% never had sexual intercourse 0 % had sex with non-prostitute women 25% had sex with prostitutes 33% had sex with both prostitutes and non-prostitute women *A total of 58% had had sex with prostitutes* *A total of 33% had had sex with non-prostitute women*

The length of time that currently married men had abstained from having sex with prostitutes varied depending on the duration of marriage as shown in Table 6.5. However, there is no fixed pattern to suggest at what stage married men were more likely to pay for sex. The recent outbreak of AIDS in the area has restrained a number of men from having sexual contact with prostitutes as shown in Chapter 8. The reasons for married men to pay for sex after marriage are given next.

Table 6.5 Per cent distribution of currently married men according to the length of time since marriage that a man has abstained from sex with a prostitute

Length of time last paid for sex	Duration of marriage			TOTAL	
	1 - 5 years	6 - 10 years	> 10 years	%	N
Less than one year	40	40	20	100	5
Between 2 and 3 years	6	33	61	100	15
Between 4 and 5 years	0	33	67	100	15
Between 6 and 10 years	0	33	67	100	15
More than 11 years ago	0	0	100	100	5

Note: Total cases=55, missing cases=10, refuse to answer=2. The large number of missing cases was mainly caused by one interviewer who did not ask the question about the length of marriage in the first few days of the survey.

6.3 EXPERIENCE OF FIRST INTERCOURSE

6.3.1 First Intercourse of Single Men with Prostitutes

It was a common practice for Thai men to have their first sexual intercourse with prostitutes at an early age. The term *khun khru* meaning 'up teacher' or to have the first sex with an experienced woman, usually a prostitute, is well recognised, as was reported by many men. The experience of having first sexual intercourse with prostitutes is strongly influenced by friends and facilitated by social drinking.

> I had my first sex at age 16 when I was at grade 10. It was about time to have sexual experience so we went to a brothel together in a group of school friends (married man aged 33, had first sex in 1976)
>
> I had my first sexual intercourse with a prostitute at age 15. My friends and I went for a celebration after winning some money from a dice game, and ended up at the brothel. I think we went because of curiosity and we wanted to have female companion (married man aged 30, had first sex in 1978).
>
> I experienced first intercourse when I was about 15-16 years old when I was in grade 10. About 10 of us went to a brothel together in a small pick-up truck. We were very drunk and we went to Kamphaeng-din (single man, aged 24, had first sex in 1985).
>
> My first sexual experience was with a prostitute at age 17. I went because all my friends had had their first sex already and they all persuaded me to do so. We drank a lot before

going to brothels. About 4-5 of us went together. I did not know how men and women had sexual intercourse, and the prostitute told me what to do for my first time (married man aged 23, had first sex in 1987).

The survey data show that many single men have prostitutes as their first sex partner as shown in Table 6.6. About 60 per cent of single men with sexual experience and currently married men said they had prostitutes as their first sexual partners. A greater proportion of single men aged below 30 had had girlfriends, not prostitutes, as their first partners. With high awareness about the sexual transmission of AIDS, an increasing number of single men probably have suspended their sexual experience with prostitutes, or they may have girlfriends as the first partner.

According to the question asked about the stage of their life at first intercourse, 14 per cent of men with sexual experience said that they were in secondary school, eight per cent were in tertiary institutes and the remaining 78 per cent had completed schooling at the time of first intercourse. About 90 per cent of them still lived with their parents when they experienced the first intercourse.

Table 6.6 Per cent distribution of men according to the type of their first sexual partner by age group

Type of first sexual partner by marital status	Age group				
	15-19	20-29	30-39	40-49	All
PARTNER AT FIRST INTERCOURSE OF SINGLE MEN WITH SEXUAL EXPERIENCE					
Girlfriend	13	33	6	a	19
Casual girlfriend	20	12	6	a	12
Friend	13	a	6	a	5
Prostitute	53	54	83	100	64
Total per cent	100	100	100	100	100
Total number	15	24	18	2	59
PARTNER AT FIRST INTERCOURSE OF CURRENTLY MARRIED MEN					
Girlfriend	a	a	13	7	9
Casual girlfriend	a	3	4	6	5
Friend	a	13	2	4	5
Prostitute	100	68	61	52	59
Wife	a	16	19	31	23
Total per cent	100	100	100	100	100
Total number	1	31	91	71	194

[a] No case.

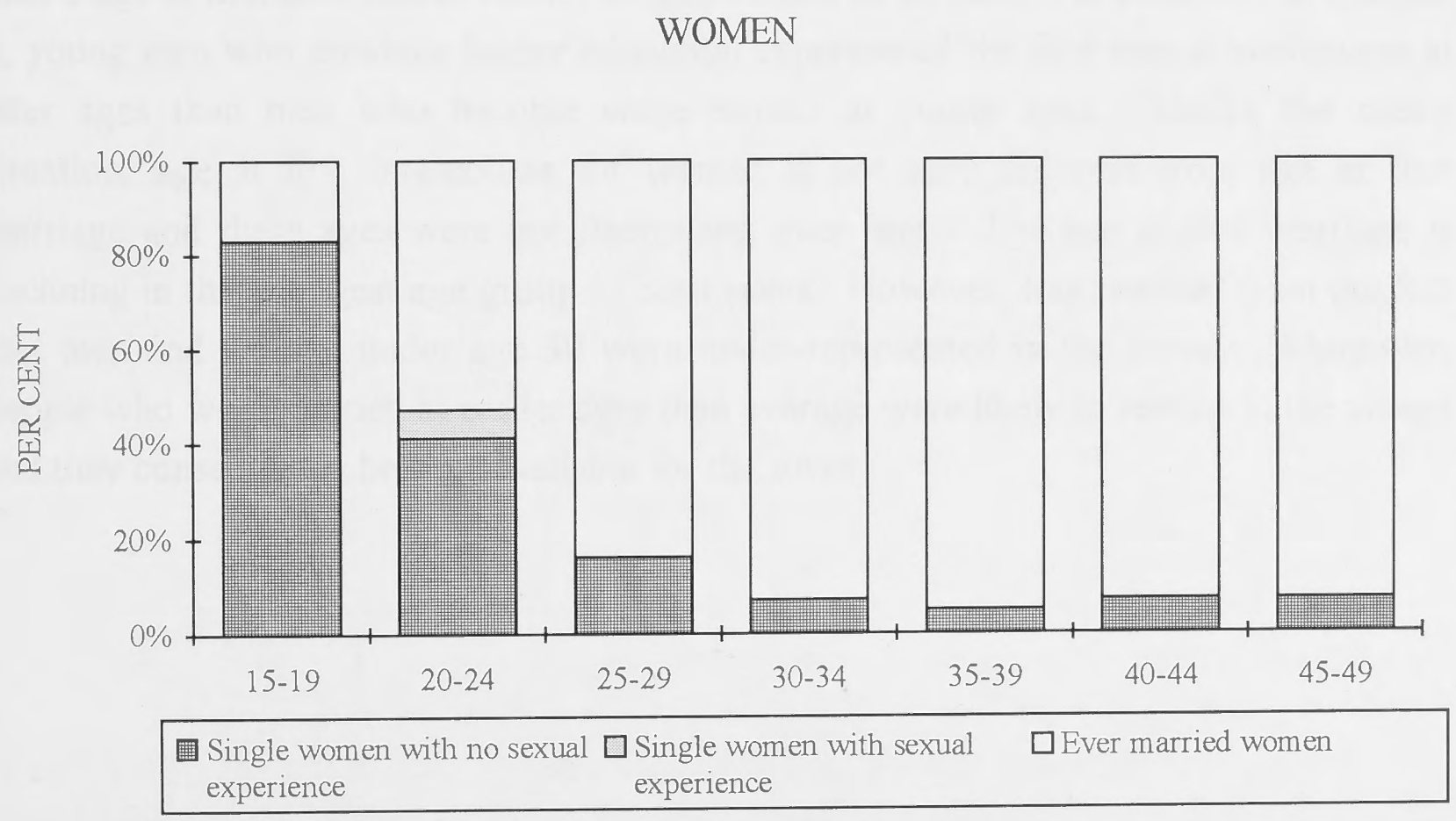
Apart from prostitutes, the term girlfriend, casual girlfriend and friend were used by men to describe the type of partners with whom they had first intercourse. These terms have

very similar meanings and may be used interchangeably by men in referring to their partners. 'Casual girlfriend' referred to a type of woman with whom men expected to have a temporary relationship. Those were perceived as women with sexual experience who enjoy having relationships with several men or those described as 'promiscuous woman', 'loose chick', 'easy girl', or 'girl with many boyfriends'. Unlike prostitutes, these women were not paid for sex. The term 'girlfriend' refers to the women with whom men expect a long-term relationship if not marriage. The term 'friend' refers to a female friend with no special commitment, but this term has a very close meaning to 'girlfriend'.

6.3.2 Distribution of Partnership Status

The partnership status of men and women is stratified by five-year age groups and marital status as shown in Figure 6.1. More than half of single men with no sexual experience were concentrated in the age group 15 to 19. Only a few single men were not yet sexually experienced at higher ages. The proportion of married women was greater than the proportion of married men in the same age group, and this is because men usually marry women a few years younger. More than 90 per cent of women were married by the time they reached 30, and similarly more than 90 per cent of men were married when they were over 35.

Figure 6.1 Per cent distribution of partnership status by current age and sex



6.3.3 Lifetable Median Age at First Intercourse and Age at First Marriage

A number of men and women were single with no sexual experience. To include single individuals without these experiences, the median age at first intercourse and the median age at first marriage were calculated by a survival lifetable approach, plotting the expected time to first intercourse and first marriage of those who had not had the experiences. The result is shown in Table 6.7. The age groups presented are ages at interview which represent the cohorts.

Table 6.7 Lifetable median age at first intercourse and lifetable median age at first marriage by sex and age group

Cohorts of age at interview	Lifetable median age at first intercourse		Lifetable median age at first marriage		Difference between median age at first marriage and median age at first intercourse	
	Men	Women	Men	Women	Men	Women
15-24	16.7	19.0	19.0	19.2	2.3	0.2
25-34	17.7	21.3	21.4	21.9	3.7	0.6
35-49	18.7	19.8	19.9	20.3	1.2	0.5
TOTAL	18.0	20.2	20.3	20.9	2.3	0.7

Men had their first sexual intercourse two years before marriage on average. However, younger men were having their first sexual intercourse at earlier ages than men in the older generation. Men aged between 15 and 24 years had their first intercourse at ages between 16 and 17 years on average. They were likely to experience the first intercourse one or two years earlier than those born ten or 20 years earlier. However, the decline in men's age at first intercourse cannot be generalised to all men. As described in Chapter 5, young men who continue higher education experienced the first sexual intercourse at later ages than men who become wage-earners at young ages. Unlike the men's situation, age at first intercourse for women is not very different from age at first marriage and these ages were not decreasing over time. The age at first marriage is declining in the youngest age group of both sexes. However, this resulted from the fact that men and women under age 30 were under-represented in the survey. Moreover, people who were married at earlier ages than average were likely to remain in the village and they consequently became available for the survey.

6.4 NUMBER OF LIFETIME SEX PARTNERS OF MEN

No women reported having had sexual contact with men other than husbands after the exclusion of three women who used to work as prostitutes. Many single men had more than one sex partner and a number of married men had partners other than their wives. The numbers of partners with whom men had ever had sexual contact in a lifetime are divided into two groups: number of sexual encounters with prostitutes, and number of non-prostitute partners.

Table 6.8 Quartiles number of sexual encounters with prostitutes and number of non-prostitute partners of men by marital status and age

	Number of sexual encounters with prostitutes			Number of non-prostitute partners			Number of cases
	1st quartile	Median	3rd quartile	1st quartile	Median	3rd quartile	
SINGLE MEN							
15-19	3	7	18	0	0	1	12
20-24	3	5	10	0	1	2	9
25-29	3	30	58	0	1	3	10
30-34	8	40	120	0	0	1	12
35-49	5	10	22	0	0	1	6
TOTAL	5	18	50	0	1	2	49 [a]
CURRENTLY MARRIED MEN - BEFORE MARRIAGE							
15-29	4	12	20	0	1	1	23
30-34	7	20	44	1	1	3	38
35-39	5	15	30	0	1	2	37
40-44	10	20	30	0	1	1	31
45-49	1	8	15	0	0	1	23
TOTAL	5	15	30	0	1	2	152 [b]
CURRENTLY MARRIED MEN - AFTER MARRIAGE							
15-29	0	0	1	0	0	1	23
30-34	0	1	4	0	0	0	38
35-39	0	1	4	0	0	0	37
40-44	0	2	7	0	0	0	31
45-49	0	0	2	0	0	0	23
TOTAL	0	0	4	0	0	0	152 [b]

[a] Missing case=1, refused=2.
[b] Missing=3.

As shown in Table 6.8, half of single men with sexual experience had had sex with only one non-prostitute partner, and another half had had sexual contact with prostitutes

about 18 times. The highest number of sexual encounters with prostitutes was among single men aged 25 to 34 who reported having had sex with prostitutes more than 40 times. The number of times that men had had sexual contact with prostitutes was very skewed. Some men reported having had a very high number of sexual contacts with prostitutes. About 11 per cent of single men who ever had sexual contact with prostitutes reported that they had had more than 100 sexual contacts with prostitutes. The number of lifetime sexual contacts of men with prostitutes was a proxy estimate. The high number reported by some men reflects regular sex with prostitutes at some stage in their life as suggested through group discussions and in-depth interviews. Life histories of men with multiple partners are given in Appendix E.

> I have frequented prostitutes all my life since I was 16. The peak period was in my early 20s during the time of army training. A group of close friends often got social drinks and went to brothels twice a week. After marriage three years ago, I still have had casual sex with prostitutes from time to time but not as often as before. My wife never complained even though she knew quite well about my behaviour. I would say I probably have had sex with about 50 prostitutes.
>
> Married man with AIDS, 33

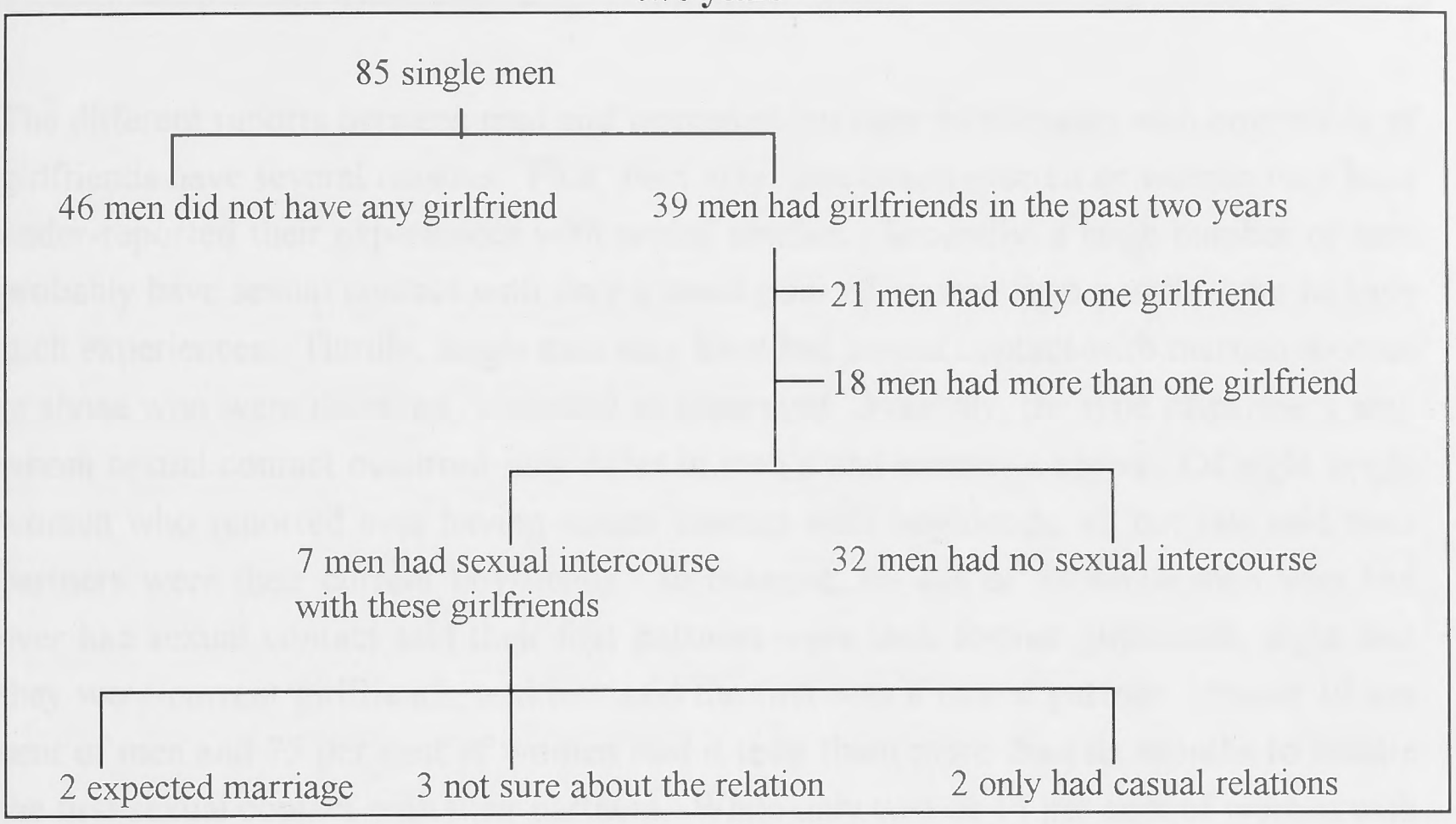
1st man: To be frank. After marriage, I never have sex with prostitutes
Headman: Who frequents prostitutes more, young men or middle aged men?
2nd man: Those in their 20s tend to be with their wives. They are not interested in prostitutes. Once they turn 40-50 when the children are all grown-up, they have money and will be promiscuous.
Headman: Did men usually frequent prostitutes when AIDS was not well-known yet?
3rd man: Of course. A lot.
4th man: Every 5-6 days, maybe.

Rural village, married men

6.5 SEXUAL CONTACT OF MEN WITH NON-PROSTITUTE PARTNER

More than one-third of single men reported having had sexual intercourse with non-prostitute women in their lifetime. However, very few of them had had sexual engagement with girlfriends in recent years as outlined in Figure 6.2. The low prevalence of sexual engagement between single individuals supports the view that on the one hand sexual engagement before marriage is disapproved and women's virginity is highly valued.

Figure 6.2 Sexual engagement of single men with non-prostitute partners within the past two years



The scarcity of suitable partners in the rural areas probably explains why a large number of single people claimed that, except for prostitutes, they had never been in a relationship with the opposite sex in a lifetime, even though about 40 per cent of them were older than 25 years. As shown in Table 6.9, most women who had ever had boyfriends said they never had any sexual contact, which contrasts with the men's answers.[1] The sexual contact here refers to physical displays of affection such as kissing, hugging or caressing without coitus between opposite sexes excluding paid partners. Only about five per cent of women who were currently married said that they had experienced the first sexual contact with other men before they married their husbands: however, this contact was just a physical display of affection without coitus. About five per cent of currently married women said they had sexual intercourse with their husbands before marriage.

1 Two single men in their early twenties were found to be *kathoeys* or men who act like women. Both said they had sex with men not women. Information about homosexuality is, however, beyond the scope of this study,

Table 6.9 Per cent distribution of single respondents reporting their lifetime sexual contact with the opposite sex

Description of relationship	Men	Women
Never had relationship with the opposite sex	35	39
Had relationship but never had sexual contact	2	47
Had relationship with sexual contact	63	14
Total percentage	100	100
Total number	85	57

The different reports between men and women about their relationship with boyfriends of girlfriends have several reasons. First, men may have over-reported or women may have under-reported their experiences with sexual contact. Secondly, a large number of men probably have sexual contact with only a small pool of women who permit them to have such experiences. Thirdly, single men may have had sexual contact with married women or those who were divorced, widowed or separated. Fourthly, the type of partners with whom sexual contact occurred may differ in men's and women's views. Of eight single women who reported ever having sexual contact with boyfriends, all but one said their partners were their current boyfriends. In contrast, 44 out of 53 single men who had ever had sexual contact said their first partners were their former girlfriends, eight said they were current girlfriends, and one said the first was a casual partner. About 30 per cent of men and 75 per cent of women said it took them more than six months to initiate the first sexual contact with their partners. While only two or 14 per cent of women with sexual contact also had had coitus with their boyfriends, about 58 per cent of men with sexual contact had had coitus with their girlfriends (risk ratio=2.24, 95% CI=1.60, 3.13). All single men who reported never having girlfriends had had sex with prostitutes.

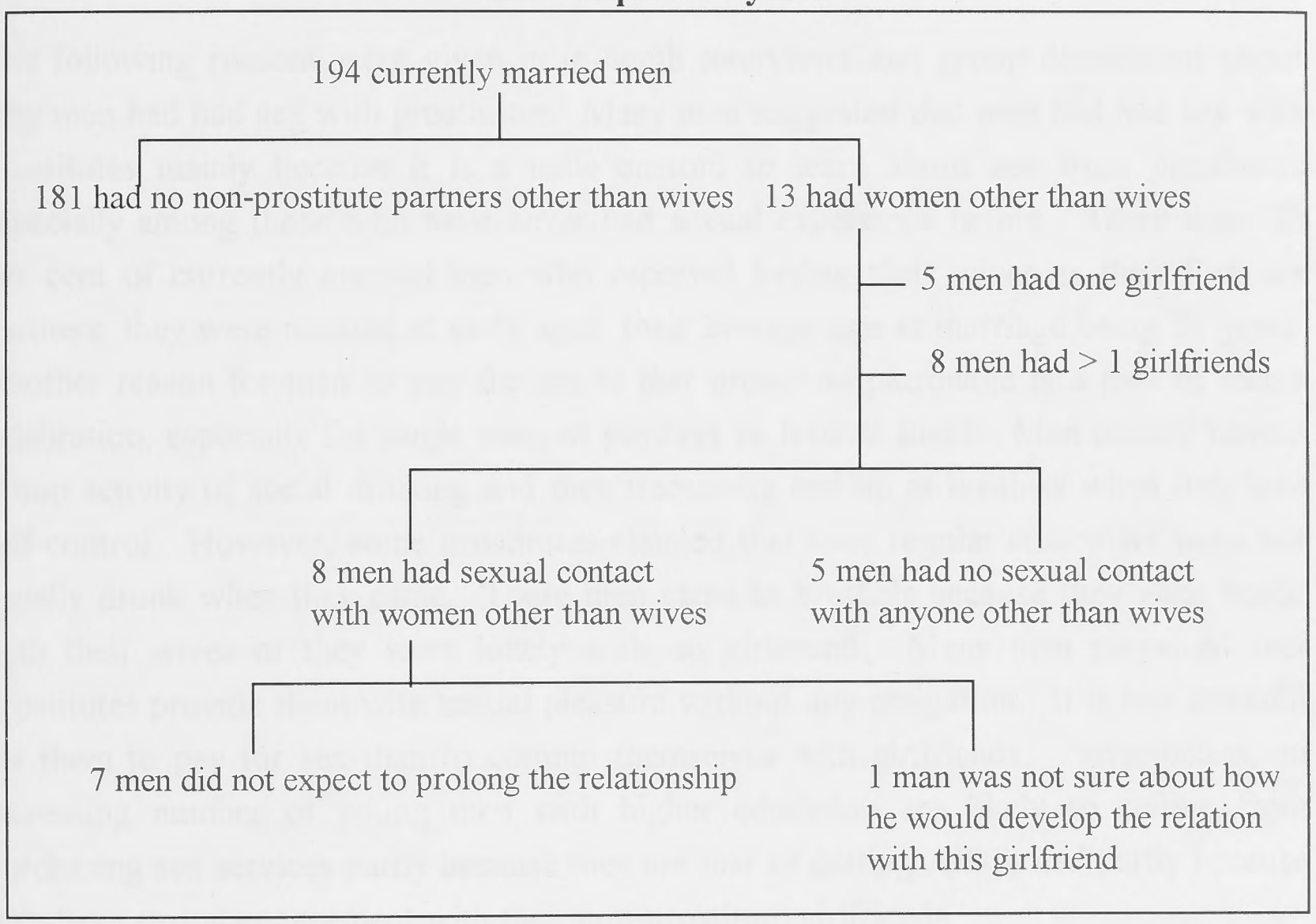
In response to a question whether they believed that they had ever had sexual relations with women who were virgins, 56 per cent of single men with sexual experience believed none of their partners were virgins, 14 per cent were not sure, and the rest believed that some of their partners were virgins. For currently married men, about 25 per cent of them believed that, other than wives, the women with whom they had had sexual relations were virgins, about seven per cent were not sure, and the rest believed that their casual partners may have had sexual relations with other men.

Information obtained from group discussions with single men suggested that it was once common for them to visit brothels until recently when they refrained from the visits because of their fear of contracting AIDS (see Chapter 8). The patronage of prostitutes was replaced by abstinence or casual sex with temporary partners. Their sexual relations with women in the village or the nearby areas were usually known about and discussed among close friends. A young man who had sexual relations with several girls was

acknowledged by his peers as a hero. Most men viewed their non-prostitute sex partners as women who enjoyed flirting with several men at the same time. Condoms might be used with these casual girlfriends if they suspected that the women had had relations with several men before. However, the use of condoms with these women was rare. They usually convinced the women that the condom would prevent pregnancy although they actually meant to protect themselves from getting AIDS.

A small number of married men had had sexual contact with non-prostitute women other than wives after marriage. However, very few of them reported having had recent contact with non-prostitute women other than wives in the past two years as outlined in Figure 6.3.

Figure 6.3 Sexual engagement of currently married men with non-prostitute partners within the past two years



Of eight married men who had sexual engagement with women other than wives, four knew that their partners had had sexual contact with other men, the other two believed that their partners were single, and the rest were not sure whether their partner had ever had sexual contact with other men. Although most of them had coitus with these non-prostitute partners regularly, all except one never used condoms with their girlfriends. As remarked through group discussions of both sexes, sex partners of married men were likely to be married women who committed adultery. It was said that they were not sexually satisfied by their husbands, or their husbands were not interested in them. A few men in the rural areas kept a second wife despite their modest economic background. However, their relationship with the second wife tended to be short since

the rural networks usually prevent them from keeping another wife without knowledge of the first wife.

1st&2nd man: About 90% of men would not practise adultery.
3rd man: Some say three kilometres away from women [wives], not three days away, one turns to others [women]. As men, who could refuse [casual sex with other women when an opportunity arises]?
1st man: Actually husbands totally give one love and one heart to their wives but along the way it [adultery] may occur. Play around for pleasure. Just play around though not taking it seriously.
Headman: To gain experience, one may take [other women], or some may do so because they are not sexually fulfilled by wives. These two are different.

Urban village, married men

6.6 MEN'S REASONS TO PROSTITUTE PATRONAGE

The following reasons were given in in-depth interviews and group discussions about why men had had sex with prostitutes. Many men suggested that men had had sex with prostitutes mainly because it is a male custom to learn about sex from prostitutes especially among those who have never had sexual experience before. There were 23 per cent of currently married men who reported having their wives as their first sex partners; they were married at early ages, their average age at marriage being 21 years. Another reason for men to pay for sex is that prostitute patronage is a part of men's celebration, especially for single men, at paydays or festival times. Men usually have a group activity of social drinking and they frequently end up at brothels when they lose self-control. However, some prostitutes claimed that their regular customers were not usually drunk when they came. These men came to brothels because they were bored with their wives or they were lonely with no girlfriend. Many men perceived that prostitutes provide them with sexual pleasure without any obligation. It is less stressful for them to pay for sex than to commit themselves with girlfriends. Nevertheless, an increasing number of young men with higher education are likely to refrain from purchasing sex services partly because they are fear of getting AIDS, and partly because they have sexual engagement with their non-prostitute girlfriends.

Headman: Why did men *aeo sao* [have sex with prostitutes]?
1st man: For fun....You know, to release tension....
2nd man: It depends on opportunities. Men go to work, right. Then, they will go with friends for a drink.....Some say there are a few new girls.....all are good looking...When you're drunk one will start urging another to visit brothels. Some might not want to do, but it is uncontrollable when you're drunk...
Headman: *Ao chai phuan fung*, 'to please the friends', right?
3rd man: Yeah, yeah.... to please the friends. When you get there, you have to take the girls otherwise they'll say you are a coward...Well, we kind of please our friends (by taking the girls)
4th man: Yes, agree..agree. *Ao chai phuan fung.*
3rd man: For those who really enjoy it, they may go alone.
4th man: Do you remember when we went to Kamphaeng-din together?

3rd man: Yeah, yeah, you took the longest time....(laughs).....

Urban village, married men

Several reasons explain why nearly half of men still pay for sex after marriage. Some men may have casual sex with prostitutes in the first few years of their marriage to show their friends that they have high autonomy and have not changed after marriage. Many men do not pay for casual sex after marriage unless there is a special occasion that they may use as an excuse to be away from home with friends. However, the visits become less frequent once they are married. Some probably do so because they are often away from home for work-related reasons, and they can afford to pay for sex for variety. Some claimed that boredom with wives or conflicts with wives had led them to seek casual sex with no need to be persuaded by friends. Because of a restricted courtship tradition in the past, husbands and wives have very little opportunity to learn about each other before marriage; their relationships are often strained and distant before they can be married (Potter, 1976: 110). It seemed to be difficult for some couples to adjust to married life. According to survey data, about 25 per cent of currently married men and women said that they knew their husbands for less than one year before marriage. About 40 per cent knew each other between one and two years and the rest for more than three years.

Moderator: Have men changed after marriage?

1st wom: Of course, they have changed a lot. When we were engaged, our boyfriends would never come close. They only watched us from the far distance. We become close and start to know about each other's real behaviour only after marriage. Men have started to drink a lot and never help us with housework.

2nd wom: After marriage, men and women are more relaxed. They become less considerate about each other's feelings. Men won't please women like before marriage because they have already had us as their wives.

Moderator: Have women changed much after marriage?

3rd wom: Yes, we do....[laughs]... Our mood changes so easily. Before marriage you don't have any disagreements, no conflict, no complaint at all with boyfriends.

4th wom: It is getting worse when you have children. Women tend to have poor blood circulation after childbirth so their mood changes easily.

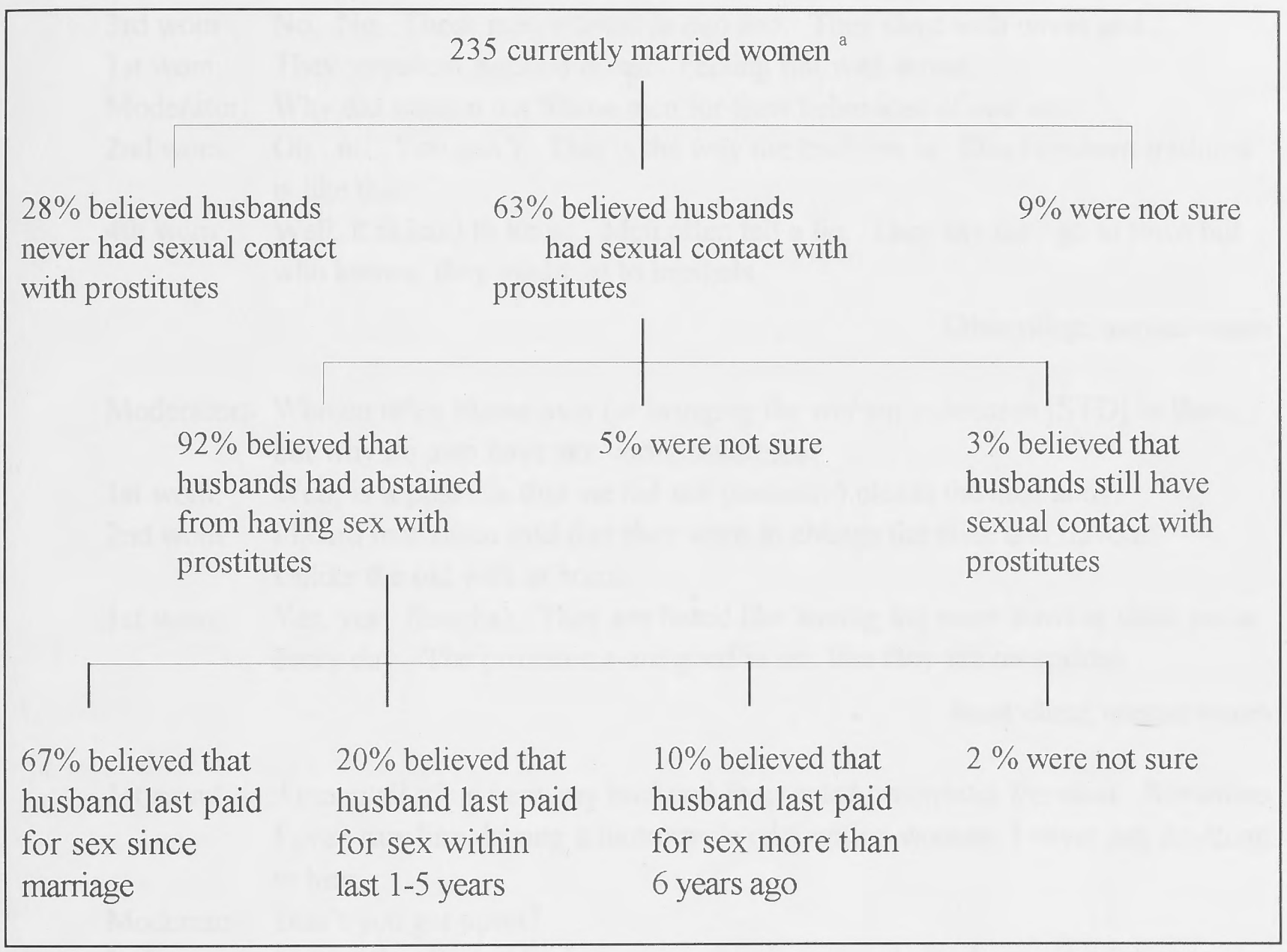
Urban village, married women

Other factors which lead some men to seek casual sex after marriage include prolonged sexual abstinence during wives' pregnancy, wives' refusal to have sex by middle age, and difficult relations between husbands and wives. These factors are detailed in the next section.

6.7 WOMEN'S ATTITUDES TO MEN'S SEXUAL CONTACT WITH PROSTITUTES

Many wives know that their husbands had had sexual contact with prostitutes but most of them believed that their husbands had already abstained from prostitutes as shown in Figure 6.4. Among those who believed that their husbands had ever paid for sex, more than half believed that their husbands had abstained from prostitutes since marriage. However, 20 per cent of them believed that their husbands had abstained from having sexual contact with prostitutes only in the last five years since the outbreak of AIDS. A few were not sure whether their husbands still frequented prostitutes or not.

Figure 6.4 Knowledge of wives about husband's sexual contact with prostitutes



[a] Missing cases=16. The high number of missing cases was mainly the interviewers' error in not asking the question.

Similarly to the men's attitude, women believed that prostitute patronage is a custom of men to become experienced about sex at an early age. Most of them accepted that sex with prostitutes is common for single men and occasionally married men pay for sex as well. Women's reactions about males' casual sex with prostitutes were varied. Some wives knew or suspected that their husbands had sex with prostitutes but did not say anything, could not say anything, or could not prove anything. Some may angrily react and force the truth from their husbands. Others try to find out from friends or relatives whether their husbands have been to brothels; or they ignore it and reluctantly allow husbands to have sex with prostitutes occasionally as they believe that it is better than letting their husbands have another regular partner like a second wife. Several women

claimed that they were happy about the spread of AIDS now because it makes married men abstain from sexual contact with prostitutes; otherwise, they could not be sure whether their husbands have sex with prostitutes or not. A number of women perceived that sexual engagement with wives may not satisfy husbands' needs as the wives are likely to be conservative. Therefore, occasional sexual contact with prostitutes may be needed by married men from this limitation of wives.

Moderator: Why do men have sex with prostitutes?
1st wom: For *khun khru*.....(laughs)
Moderator: What do you mean by *khun khru*?
1st wom: To experience sex.
2nd wom: Take young males to practise sex with different women.
Moderator: Well, you mean men in their 30s or 40s still *khun khru*?
3rd wom: No. No. Those men wanted to *aeo sao*. They slept with wives and....
1st wom: They somehow became bored. Feeling flat with wives.
Moderator: Why did women not blame men for their behaviour of *aeo sao*?
2nd wom: Oh...no.. You can't. This is the way the tradition is. Our Northern tradition is like this.
4th wom: Well, it is hard to know. Men often tell a lie. They say they go to town but who knows, they might go to brothels.

Urban village, married women

Moderator: Women often blame men for bringing the women's diseases [STD] to them, but why do men have sex with prostitutes?
1st wom: Well, is it possible that we did not (sexually) please the husbands?
2nd wom: I heard men often said that they want to change the taste and flavour. Unlike the old wife at home.
1st wom: Yes, yes...(laughs)...They are bored like having the same bowl of chilli paste every day. The prostitutes are good in sex like they are on springs.

Rural village, married women

1st wom: Among all of us here, my husband frequented prostitutes the most. Sometime I even saw him driving a motorcycle past with a woman, I never say anything to him.
Moderator: Don't you get upset?
2nd wom: Not really. Probably, I am so used to it now and also I cannot ask him to stop. It is like asking him to go more often.

Rural village, married women

Women claimed that it is inappropriate for them to initiate sexual intercourse even with their husbands, and that married men tend to have sex with prostitutes after marriage because prostitutes are willing to change coital position to please men.

Moderator: Why do men often have sex with prostitutes?
1st wom: Men have high sexual desire. They meet pretty women [prostitutes] and would like to try.
2nd wom: They are drunk or some would like to have sex with younger girls.
3rd wom: It depends. Some men have very beautiful wives but still go to brothels.
4th wom: Men say that sleeping with wives is like sleeping with a dead log. No

response, always in the same position. The prostitutes are better in sex and do what they want them to do....they please men by doing positions or *om* (fellatio). I think, somehow women need to know more about sex. We only do it in one position. Otherwise men enjoy sex with prostitutes more.

5th wom: Prostitutes have several positions and men like it.

Urban village, married women

Moderator: I have heard some women could initiate intercourse first now.
Everyone: (laughs)....No, no.. women should be reserved about this.
1st wom: Still doesn't know his [husband] heart after living together for 20 years.
4th wom: He may be surprised how come my wife has changed tonight.

Urban village, married women

Table 6.10 shows the percentage distribution according to a belief whether or not the inability of wives to sexually satisfy their husbands' needs may cause married men to have sex with prostitutes. Women were more likely than men to agree with this statement. Those who believed that their husbands had paid for sex after marriage are more than twice as likely to agree with this statement as men who had paid for sex after marriage (risk ratio=2, 95% CI=1.56, 2.57).

Table 6.10 Per cent distribution according to a belief that the inability of wives to sexually satisfy their husbands leads married men to pay for sex with prostitutes

	Agree	Disagree	Undecided	TOTAL	
				%	N
WOMEN					
Single women	45	22	33	100	58
Currently married women	68	23	9	100	251
Currently married women who believed that their husband had paid for sex after marriage	73	18	9	100	56
MEN					
Single men	39	35	26	100	85
Currently married men	35	49	16	100	194
Currently married men who ever paid for sex	34	51	15	100	155
Currently married men who had paid for sex after marriage	32	53	15	100	75

6.8 SEXUAL RELATIONS WITHIN MARRIAGE

6.8.1 Age and Marriage Duration Effects on Coital Frequency

Little is known about sexual engagement between husbands and wives in Thai society. Concerns with the sensitivity of the topic and the quality of the information obtained have led to lack of knowledge in this area. However, attempts to explore information about coital frequency have been made in Thailand with some satisfactory results by interviewing a large number of married women in 1967 and 1987 (Udry, Deven and Coleman, 1982; Chayovan and Knodel, 1991) and national surveys of married men and women in 1990 and 1993 (Sittitrai et al., 1992; Guest and Thongthai, 1995).

In this study, only 12 women (5%) and six men (3%) refused to answer about coital frequency. However, the refusal rates do not affect the validity of reports about coital frequency. Ninety-nine pairs of husbands and wives were interviewed about coital frequency; the answers were compared. In nine couples either husbands or wives refused to answer. Of the remaining 90 pairs, similar coital frequency was reported by 49 couples. The husband reported higher coital frequency than the wife did in 28 couples and the wife reported higher coital frequency than the husband in 13 couples. Men were likely to over-report or women to under-report coital frequency. [2]

In Table 6.11, the mean coital frequency reported by men was greater than that reported by women. However, the variation of report by men is greater than that reported by women as indicated by high standard deviation. Despite the report of higher coital frequency by men, it was found that the frequency of sexual intercourse declined by age and marriage duration for both sexes. However, the decline of coital frequency by duration of marriage reported by women was inconsistent. Variation in coital frequency by fertility regulation is given in Chapter 7, regarding the attitudes and beliefs about the effects of contraception on sexuality.

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2 Similar report means the average coital frequencies reported by wives and husbands are not different by more or less than two. A range of plus or minus two is given for similar answers because the question asked about coital frequency did not specify the range of answer: Q206. Within the past year, how many times per month did you have sexual intercourse with your spouse? The answers given may range from the highest to the lowest average number per month. A more specific answer will be obtained if the question is asked about coital frequency within the last month only. When the approximate figures were given, e.g. 2-3 or 4-5 times per month, only the higher number was taken for consistency.

Table 6.11 Mean coital frequency in the last month of currently married men and women by selected characteristics

Selected characteristics	Men [a]		Women [b]	
	Mean	SD	Mean	SD
Mean coital frequency per month	8.3	7.1	6.0	4.9
Age				
15-29	10.1	7.9	6.9	4.7
30-39	8.4	6.7	6.3	5.0
40-49	6.6	5.7	4.9	5.0
Years since marriage				
1-5 years	9.2	7.1	6.2	4.7
6-10 years	9.0	7.6	5.2	3.3
11-20 years	7.8	6.7	6.4	5.3
21-30 years	6.9	7.0	5.9	6.2
Number of children				
None	9.1	1.3	5.2	3.1
1-2	8.2	7.1	6.2	5.2
3-6	5.8	4.7	3.9	2.8
Education				
Up to 7 years	8.0	7.0	6.1	5.1
More than 7 years	8.0	7.0	4.9	3.2
Type of contraception used last year [c]				
Pill	9.3	8.2	6.5	5.7
Injection and Norplant	8.2	7.2	6.0	4.0
Female sterilisation	7.8	6.3	5.6	4.2

[a] Total number is 187. Sleep separately from wife=1, refusal=5, missing=1.
[b] Total number is 229. Sleep separately from husband=5, refusal=12, pregnant=2, missing=3.
[c] Only the three most popular methods selected.

Some cross-sectional and longitudinal studies similarly show that coital frequency declines by age and marriage duration (Udry, 1980; Udry et al., 1982; Chayovan and Knodel, 1991; Wellings et al., 1994). However, the decline in marital intercourse by increased age is seen as a primarily function of females' but not males' ages, and those married the shortest time have the most rapid declines in coital frequency (Udry and Morris, 1978; Udry, 1980). The prominent influence of female age on declining coital frequency is believed to be attributable to the decline in female libido caused by declining female androgen levels over the childbearing period (Udry et al., 1982). The same argument was found through group discussions, that sexual interest declines by women's age and duration of marriage. Weariness from daily work is a significant factor leading to lack of sexual interest among many peasant men and women.

Moderator: What do you think about sexual relations at your ages [35-53]?
1st wom: Well, it is common. We are getting old - we still have sex but not so often.
2nd wom: (laughs)...It becomes common like doing other activities. Just feel numbed

really. Indifferent, no more excitement.
3rd wom: It is kind of getting tasteless.
4th wom: For men, they still need it.
Moderator: Have you refused your husband sometimes?
Everyone: (laughs)....Yes, sometimes when we are tired and not well.

Rural village, married women

Headman: Some say men go to brothels at two periods: when they are single and when they turn 40.
1st man: Of course, women don't have any feeling [of sexual desire] when they turn 40.
Headman: Do wives refuse intercourse at these ages?
2nd man: We are getting older every day. The feeling is indifferent, not very alert. Yes, it does happen that wives refuse intercourse.
3rd man: Just like you see each other's face every day [and become bored].
4th man: I disagree. If it is a true love, you won't be numbed or feel bored with each other. By age 40 like us, it would be a different story if you work comfortably in the air-conditioned room. But we work hard digging ground all day, do you have any mood left [for sex] when you are weary? Your wives are tired just like you. You finish dinner, take a bath and go to sleep. It becomes infrequent then. But your affection for each other remains the same.
Headman: How about men's desire for sex [at old age]? Does it still exist?
1st&2nd man: Men always have it.
2nd man: The Chinese say until age 80 for men and 50 for women.
3rd man: Until they *hmot luat-hmot radu* 'finish menstruation' for women. After that women won't have much desire for sex.

Urban village, married men

The concept of old age among Thais is worth noting. As marriage is generally expected, people often suspected that men and women who are still single by age 30 may be homosexuals although this is not the case. Married couples usually consider themselves old when they have grandchildren which often happens in their 40s. Grandmaternal abstinence has been documented in many societies (Caldwell and Caldwell, 1977). Because they believe that women are not capable of conceiving a child at later ages, a few stop using contraception and become pregnant. It is a cause of great shame if the woman gets pregnant when she has already become a grandmother: this was called the 'shame at grandmother pregnancy syndrome' (Mougne, 1981: 95).

Sexual engagement within marriage may be stressful for some couples as several factors other than age and marriage duration need to be considered. The housing conditions may affect the sexual relations of the couples as earlier noted that the 'nature of the house made of bamboo made it impossible to keep sexual relations secret. Being heard by others was a matter of great shame'(Cohen and Wijeyewardene, 1984: 258). Although many houses in the village were built with more permanent materials like wood, the hot and humid climate does not allow houses to be made soundproof. As remarked in group discussions, some parents needed to be careful of being heard during sexual intercourse by their children who usually sleep with them.

6.8.2 Problems of Sexual Relations with Spouse

All currently married respondents were asked whether they had experienced any problems in having sexual engagement with their spouses. If the answer was yes, the description of problems and the person they turned to for advice were asked. Of 445 currently married respondents, 23 (5%) reported facing some problems. This number may be under-reported considering that the respondents were probably reluctant to tell the interviewers about their personal affairs despite no refusals. Among those reported as having ever had difficult experience of sexual engagement with spouse, 65 per cent said they had never discussed their problem with anyone, 20 per cent sought advice from the public health staff, and the rest discussed the problem with their spouse or close friend.

Twelve out of 99 couples reported having problems in sexual engagement with spouses. However, the claim was reported by either the husband or wife on one side only. Only one couple, both husband and wife, said that they had experienced problems in sexual relations with the spouse, but the problems were differently reported. This couple had been married for 23 years and had two daughters; the wife was 42 and the husband 49. The wife said that she could not respond to her husband's frequent demands for intercourse because she was so weary from farming and daily work. She claimed that her husband's sexual desire had increased after he had a vasectomy a few years ago. In contrast, the husband complained that weariness from work did not leave him any energy for sex. The wife perceived that her husband had too much sexual desire at this age, but the husband thought that he was not able to have as frequent intercourse as in the past. The average coital frequency was three and five times per month reported by wife and husband respectively. Even though the husband did pay for sex about five times before marriage, he had stopped having sex with prostitutes after marriage. Sexual problems often led to misunderstanding between the couples, for example:

> I don't have any desire for sex. I don't want to have sex but my husband never understands me. Last year, the relationship went sour. My husband suspected that I probably kept denying him because I had another lover, but in fact I just didn't feel like doing it.
>
> Married woman, aged 35

Of 16 currently married women (6%) who reported problems, half complained that they did not feel like having intercourse but could not resist their husbands. Three women in their early 40s said that their husbands demanded intercourse too often. Two women both aged 36 had painful intercourse.[3] Another one was afraid of contracting AIDS and

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3 One of them said that she had experienced painful intercourse for over a year. She had also experienced hot flushing on the face, hands and feet, and night sweating. These symptoms caused her much anxiety because she suspected that she probably had developed AIDS symptoms after her brother, of whom she was taking care, died from AIDS two months ago. Apart from the spiritual medium who suggested that she had anaemia, she did not speak to anyone else about her anxiety. She feared that other people might accuse her of contracting AIDS from her brother. She refused to have sex with her husband for over two months because she was afraid that he might

refused to have sex with her husband unless he used condoms. She lacked trust in her husband who might have had sexual intercourse with women other than herself. Two women perceived that the inability to conceive a child was a sexual problem.

Of seven men (4%) who reported sexual problems, three who were all in their 40s said they were too weak or too tired for sexual engagement at their ages. One man had experienced premature ejaculation for over ten years, since age 25. Another man said he had no interest in sex with his wife even though the marriage was only four years old. Similarly to the women, two men perceived that their inability to beget children was a sexual problem. The small number of reports by men about problems in sexual engagement was not surprising as men and women usually perceived sex to be something initiated by men not women. Sexual intercourse was seen as one of the wife's responsibilities; she could be reluctant, but could not avoid it.

1st wom: We work all day and become so tired and hungry. We don't have a mood [for sex] at night.
Moderator: How do you respond to your husbands then?
2nd wom: Just do and finish it.
3rd &4th wom: Yes, just sleep.

Urban village, married women

Moderator: Have you ever refused intercourse with husband?
3rd wom: Sometimes.
Moderator: Do they get angry?
3rd wom: Of course, sometimes the husband still *hna-ngo* ['bending face' or a face grimace when one is upset] in the morning....(laughs)
Moderator: What occasion do you refuse intercourse with husband?
1st wom: On the day that you work hard and tired - something like that.
4,5th wom: We want to rest.

Rural village, married women

Moderator: How do you respond to him though [when you do not feel like having sex]?
1st wom: I just sleep. Indifferently - just like ordinary sleep.
Moderator: Some say this probably makes men patronise prostitutes.
2&3rd wom: Yes, possible. I agree with what people say. Men go to prostitutes then.
1st wom: No, no. Well, women also have moods sometimes. But if you are not in the mood and the husband insists, you have to let him do it.
Moderator: Can one refuse?
2nd wom: Hurr.. never.
1st wom: They will complain and think that you probably have an affair. How come you were okay before, but not now? Even if you don't enjoy it or don't have any feeling, you still have to do it.

Rural village, married women

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get AIDS from her. Her husband did not understand why she refused him and she was becoming worried that her husband might go to prostitutes instead. After a long discussion, she was advised to seek medical attention since it was suspected that she might be experiencing early menopausal symptoms.

Sexual desire by women is perceived as shameful since it should be suppressed even with husbands: women with sexual desire are condemned as dangerous, corrupting and polluting (Thitsa, 1980: 20). Some women claimed that they had never experienced orgasm, and a few women did not know what it was although they had been married for many years. Some women did not expect orgasm because they believed only men would have such experience. The lack of knowledge about sexuality probably led them to have certain beliefs about sexuality as discussed in Chapter 7.

Moderator: It is difficult to say about the feeling. Young men can fly a kite [masturbate] to help themselves, right. How are women?
Everyone: Never, never.
1st wom: Women have no need to masturbate.
2nd wom: Women suppress it.
3rd wom: Never heard a report of women raping men...(laughs)...
Moderator: What happens to women after sex?
1st wom: Sometimes you are left alone, *arom khang* [unfulfilled sexual feeling] .....(laughs)...
2,3rd wom: What? *Arom khang*? What is it? We never experience that. We finish when they [the husbands] finish.
1st wom: After sleeping with women, men fall asleep and snore right away - leave women with unfulfilled feeling. Women cannot complain for anything. You just close eyes and try to sleep.
2nd wom: It never happens to me.
4th wom: It happens. Sometime yes, sometime no.
5th wom: You just grumble to yourself ...(laughs)...
1st wom: You can't [grumble], the children are there. They will peek at you then [if the noise is heard by the children].

Urban village, married women

6.9 PREGNANCY AND SEXUALITY

It has been suggested that the wife's pregnancy is the period during which some married men have sex with prostitutes. The coital activity of couples may be affected during pregnancy: some women may experience changing moods and physical discomforts; some may be afraid that making love will hurt the baby or lead to miscarriage or premature birth; changing of position may be needed late in pregnancy (see Pincus and Swenson, 1992). In practice, it is unusual for doctors or health care workers to discuss sexuality with pregnant women, probably because there are only a few health care personnel serving a large number of women, or maybe people are reluctant to discuss sexuality. This weakness has left Thai women with no clear knowledge but suspecting that coital activity may need to be changed during the prenatal period.

Despite the lack of information on coital activity during pregnancy, postpartum abstinence has interested researchers for decades as an important factor in the containment of human fertility (Davis and Blake, 1956; Caldwell and Caldwell, 1977; Bongaarts, Frank and Lesthaeghe, 1984). It is also an important factor causing men to seek sex from other women as reported in sub-Saharan Africa (Caldwell and Caldwell,

1993). Gestational abstinence has attracted little interest, however, since it does not directly affect fertility. However, when the research interest turns from human fertility to sexuality, the role of gestational abstinence cannot be overlooked. The total period of abstinence may be prolonged as long as nine months when gestational abstinence is added to postpartum abstinence. In Thailand where prostitute patronage is evident, it is necessary to explore whether sexual abstinence during pregnancy has led married men to have casual sex with other women during this period.

6.9.1 Beliefs and Practices about Pregnancy and Sexuality

Some men claimed that married men tend to seek casual sex with prostitutes during their wives' pregnancies:

> Not many men in this village have sex with prostitutes any more. In the past years, it was common for both married and single men to have sex with prostitutes from time to time whenever they had a chance. As for married men, they probably have sex with prostitutes during wives' pregnancy. This has changed recently when the villagers have seen people infected with AIDS with their own eyes. They started to believe that AIDS is real. Only some single and very few married men who probably have problems with wives still have sex with prostitutes nowadays.
>
> Headman aged 43 years

Headman: Some said men had sex with prostitutes when the wife is pregnant?
1st man: Possible.
2nd man: Especially in the first month after giving birth. Depends on the age too.
3rd man: I did after the birth of my first child, not the second one though. I got older and realised that it was not appropriate.

Rural village, married men

It is reported in the literature that some Northern Thai beliefs and practices about childbith may affect the sexual relations of married couples. There is a traditional belief among Northern women, especially those living in rural areas, that after giving birth women should observe a confinement period called *yuu-duan* in order to prevent the occurrence of puerperal insanity or *lom phit duan* as fully described in two ethnographic studies (Mougne, 1978; Muecke, 1979).[4] Although there are several practices postpartum women should follow during this period, the three most common things that they should avoid to prevent the occurrence of *lom phit duan* are: prohibited foods; bad odours such as burning rubber or grass; and exposure to wind. Women from the Northern villages, especially those who are over 30, still have a strong belief in *yuu duan* and *lom phit duan*. The postpartum woman is expected to remain within her room for about one month keeping herself clean and warm. Despite the usual hot climate, they

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4 *Yuu-kam* and *yuu-(fai)-yen* are other terms used for this period of postpartum restriction. However, *yuu-duan* is the most common term among the informants. To *yuu-duen* is to stay a month. The practice of postpartum restriction of northern women is very similar to practices described among Chinese and Vietnamese women (see Pillsbury, 1978; Dennerstien et al., 1991). From personal communication with Thai women from other regions, it seems that *lom phit duan* is peculiar to the northern women. Thai women in other regions are likely to *yuu-fai* or to lie close to the fire, not *yuu-duan*, after delivery and there is no belief in *lom phit duan* among women in other regions (Jirawatanakul, 1994).

would wear clothes that cover most of their body plus woolly hat and socks to insulate the body from the wind. To prevent the wind from entering the room, the windows and the door of the confinement room are kept shut at all times.

Similarly to the explanations reported by Mougne (1978) and Nimmanhemin (1987: 136-137), a married woman with two children aged more than ten years explained the logic of her belief about *yuu-duan* that women push *lom* or the air (within the body) heavily for a long time to deliver the baby and this strong push has opened the skin pores throughout their bodies.[5] Therefore, postpartum women are at risk of becoming ill and tiring easily since they have lost the balance of the wind element inside their bodies. Keeping themselves warm by insulating their bodies from the wind and restricting themselves to certain rules during the postpartum period will adjust this imbalance. If the women do not follow such rules, eventually they will develop symptoms ranging from minor disorders such as chronic headache, palpitations, mood swing and irritability to severe disorders like insanity, as seen or experienced by several women.

A similar example was given across several villages about women who did not practise *yuu duan*: a few years afterward some women with the *phit duan* symptoms became insane, for example they would strip off their clothes in public without being conscious of their behaviour whenever they developed the symptoms.[6] Most women in the village see this example as resulting from negligence of traditional customs and they tend to follow postpartum restrictions. There may be an association between the symptoms of *lom phit duan* and those of postpartum psychosis but the subject has not been well documented though this was attempted by Muecke (1978). The symptoms of *lom phit duan* are frequently cited by young and old married women in the rural areas of the Northern provinces as among the most important factors influencing their health: *jai hin*, *jai khun*, *lom bo choi* or *hngut hngit ngai* means 'easily irritable'; *luat lom bo di*, 'poor blood and wind circulation', sleeplessness; *kwan oon* 'to lose heart or courage'. These *lom phit duan* symptoms can be almost anything that happens to women and these are the symptoms in which many doctors probably have little interest, citing stress or hormonal deficiency as the cause.

How *yuu-duan* may affect the sexual relations of married couples has never been explored in detail even though it has been suggested that postpartum women should not have sexual intercourse throughout the restricted period which can range from a few weeks to a few months (Pillsbury, 1978: 14; Mougne, 1978: 80). Through group

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5 The association of an illness with wind is not new since this is the traditional belief among Thais and people from other countries like India, Sri Lanka, Indonesia, Malaysia and China, that the human body is composed of four elements: earth, water, wind and fire. Illness occurs as the result of an imbalance of these elements (Bamber, 1987). The belief among the northern women is that 'childbirth is aided by the downward movement of wind, the air element in the body, which is seen as pushing the baby downwards on its way into the world' (Mougne, 1978: 75). In the modern practice of childbirth, Thai doctors and nurses use the term *lom beng* or an urge to push from air to describe the strong push during contraction.

6 As a local person from Chiang Mai, I saw a woman in her 50s strip off her clothes in public in the early 1970s. I was told that this woman had developed the *phid duan* symptoms.

discussions, it was learnt how the symptoms of *lom phit duan* may prolong sexual abstinence during the postpartum period. The development of *lom phit duan* symptoms is beyond women's control and this is given as one of the reasons why some wives refuse intercourse with their husbands by saying they are ill with *lom phit duan*.

1st wom: A drunk person cannot be close to me. It starts symptoms of (*lom) phit duan*.
Moderator: What do you mean by *phit duan*?
1st wom: I will be dizzy whenever I smell bad odours. I experienced a headache from childbirth. Women experience blood loss through childbirth, you know.
Moderator: I also feel dizzy sometimes. Is it *phit duan's* symptoms?
2nd, 3rd wom: No, you have to experience childbirth first - bleeding from childbirth. Postpartum is important because it is the period that your bodies expel bad blood and rebuild new blood.
4th wom: Women in the new generation do not believe this.
5th wom: They should be careful. It is heredity. Daughters will get the *phit duan* symptoms just like the mothers. Remember what happened to Lan and other girls? They took off their clothes and stood in a row naked [when they developed symptoms of *phit duan* last time].
1st wom: They were modern and did not follow the traditional practice and look what happened to them.
3rd wom: You are supposed to remain in the room for a whole month but some girls took motorcycles to the market within two weeks of giving birth.
Moderator: How long do women need to practise *yuu duan*?
2nd wom: Some say until they finish breast feeding.
3rd wom: Until the child is 5-6 months old.
Moderator: Would the symptoms of *phit duan* affect your relations with husbands?
4th wom: If the husbands really care, one will not be disturbed. A few men may be irritated (by women's symptoms) during this period.

Urban village, married women

6.9.2 Childbirth-related Sexual Abstinence

Three durations of sexual abstinence related to the last childbirth reported by currently married men and women with at least one live birth are given in Table 6.12, including duration of abstinence before and after childbirth and the total duration which combines both durations. Two pregnant women and three postpartum women were excluded from the analysis because they had not completed the period of potential abstinence at the time of the survey. The median is used to summarise the duration owing to a few outliers. The duration of abstinence was reported in months. When the approximate figures were given, for example 2-3 or 3-4 months, only the higher number was taken for data consistency.

About half of currently married males and females reported that for the last childbirth the total period that they abstained from intercourse with spouses was five months, or three months before and two months after childbirth. The Thailand Demographic and Health Survey (TDHS), which involved a national representative sample of 6,775 ever married women aged 15-49, suggests a median of 2.1 months or a mean of 3.5 months for

postpartum abstinence of women (Chayovan, Kamnuansilpa and Knodel, 1988: Tables 2.4, 2.5).[7] The average duration of postpartum abstinence in this study is similar to that of TDHS even though, to minimise recall bias, the latter based its analysis only on women who abstained within the three years before the survey. The duration of abstinence before childbirth is not available from the TDHS.

Among 381 people who had experienced childbirth or whose wives had experienced childbirth, 14 per cent reported that they had not abstained from intercourse for the last childbirth, 63 per cent had abstained in the third trimester of the pregnancy, 13 per cent had abstained when they knew that they or their wives were pregnant, and the remaining 10 per cent had abstained from intercourse during the first and the third trimester.

Table 6.12 Duration of sexual abstinence at last childbirth reported by currently married men and women with at least one live birth

Duration of abstinence	Median duration (in months) Women [a]	Men [b]
Before childbirth [c]	3.0 [0,9] [d]	2.0 [0,9]
After childbirth	2.0 [1,9]	2.0 [1, 9]
Total duration	5.0 [1,15]	5.0 [1,17]

a N=201, missing cases=5, do not remember=9
b N=160, missing cases=5, do not remember=1
c About 14 per cent of women (n=28)and men (n=23) reported not abstaining before childbirth.
d. Numbers in square brackets are minimum and maximum length of sexual abstinence in months.

Among a few potential biases in determining for duration of abstinence for the last birth, memory lapse and time reference play important roles. The figures given in Table 6.12 are derived from the respondents whose last childbirth, or whose wives' last childbirth, took place at a different period. Women who last gave birth a long time ago may not remember the information correctly compared to those who gave birth recently. Because of the outbreak of AIDS in recent years, women who recently gave birth may also abstain from sex with their husbands for a longer period than those who gave birth in the early years as they feared that their husbands might have had sexual intercourse with prostitutes during their pregnancy. Moreover, the age of the couples at the last childbirth is another factor which may extend the duration of sexual abstinence related to childbirth. As suggested earlier, coital frequency may decline with age and duration of marriage or partnership, so those who give birth at a later age may have a longer duration of abstinence. However, the survey data are not available to adjust for these

7 The two sets of estimates are not comparable because the measures of central tendency of the two estimates are different. As suggested by the authors, the latter is indirectly calculated from prevalence/incidence estimate.

factors. This extended duration of sexual abstinence related to childbirth probably makes some married men seek casual sex with other women during this period.

6.9.3 Sexual Contact of Men with Other Women during Wives' Pregnancy

About 80 per cent of currently married men said they did not have sex with any other women during their wives' last pregnancy. However, 20 per cent of them said that, while abstaining from sex with their wives during the last pregnancy, they had sex with prostitutes and three per cent had sex with other women. As with the men's answer, 78 per cent of women believed that during the period of abstaining at the last pregnancy, their husbands did not have casual sex with other women. About seven per cent were not sure about their husband's behaviour and the remaining 16 per cent believed their husbands had casual sex with prostitutes while abstaining from sex with themselves.

Headman: Men often go *aeo sao* when wives are pregnant.
1st man: Yes, that's right - married men go *aeo sao* when their wives are pregnant.
2nd man: Even in the first month after giving birth....it depends on their age.
3rd man: I went *aeo sao* when my wife was pregnant with the first child but not the second one. That is because I become more conscious when I am getting older.
2nd man: Hey, record it and show to his wife.
3rd man: I am going to be killed...(laughs)
1st man: These days I dare not go *aeo sao* even if I have money [because of AIDS].

Urban village, married men

Of 34 men who had sex with prostitutes during their wives' last pregnancy, 90 per cent had had intercourse with prostitutes before marriage. Four of them had given up sex with prostitutes once they married but had started to have sex with prostitutes again when abstaining from sex with wives. However, men who had ever had sex with prostitutes were more likely to have casual sex again with prostitutes while they were sexually abstaining from wives during pregnancy (risk ratio=1.24, 95% CI=1.09, 1.42).

6.10 DISCUSSION

The sexual relations among Thais obviously comprehend the relationship of three parties: men, prostitutes and non-prostitute partners. Men are the focus of discussion about sexual relations because they can develop relations with a range of different types of women. Three kinds of men's sexual relations are summarised below.

6.10.1 Sexual relations of men with wives or stable partners

The relationship with the opposite sex among Thais before marriage has been different between the sexes. While women are expected to have sexual relations with their husbands only after marriage, the majority of men have gained their sexual experience with prostitutes and a number of them have had sexual experience with non-paid partners before marriage. Men on average had experienced sexual relations for two years before marriage, in contrast to women. The discrepancy between age at first intercourse and

age at first marriage of men and women is in accord with the earlier claim that the strict rules of sexual relations among Thais apply to non-prostitute women only. Nevertheless, about one-third of men claimed to have had sexual relations with non-paid partners other than their wives or prostitutes before marriage; this raises the question who these women are. This issue is discussed in subsection 6.10.3.

Although a large number of men have had sexual experience with prostitutes, nearly half claimed to abstain from liaisons with prostitutes after marriage. Furthermore, the majority of men who have sex with prostitutes after marriage do so regularly. The effect of the AIDS outbreak on men's sexual contact with prostitutes and other women is described in Chapter 8.

There is a general belief that women are prone to physical and emotional abnormalities after giving birth; hence, sexual abstinence of women during pregnancy is required as an attempt to prevent the occurrence of postpartum abnormalities. However, men can claim sexual abstinence with wives during pregnancy as an excuse to have sex with women other than their wives during that time as was done by one-fifth of currently married men. In addition, women can use the symptoms of postpartum abnormalities to refuse sexual intercourse with their husbands from time to time after they have given birth.

6.10.2 Sexual contact of men with prostitutes

It has been a common practice of Thai men to have their first sexual experience with prostitutes, and nearly half have continued to do so occasionally after marriage. The sexual contact of men with prostitutes before marriage is perceived by both men and women to be normal behaviour. Single men are encouraged by their peers and are led by social drinking to have their first sexual experience with prostitutes. Furthermore, prostitute patronage can be seen as a form of entertainment providing men with pleasure; thus, it has been substantially promoted as an activity of single and married men who usually visit prostitutes in a group of friends.

The information about sexual relations within marriage explains why some men pay for sex after marriage. Coital frequency with the spouse declines by age and marriage duration suggesting that the interest in sex between husbands and wives declines. However, it is believed that men have a greater interest in sex than women in general; in contrast to men who keep their sexual interest with increased age, it is believed that women's interest in sex progressively declines with increased age, particularly when they are approaching menopause. It is also believed that women should be restrained and should not express their sexual needs even with their husbands. These different ideas of the sexual interests of men and women have led some wives to believe that they are incapable of sexually satisfying their husbands; thus, some of them do not object if their husbands seek sexual contact with prostitutes from time to time as long as their visits are

infrequent. They allow this also to prevent their husbands from having extramarital affairs with non-prostitute women which might threaten their marriage.

6.10.3 Sexual relations of men with non-paid partners

About one-third of married men claimed to have had sex with non-prostitute women other than their wives before marriage and about seven per cent have had non-paid partners after marriage. This information contrasts with the general belief that women should preserve their virginity until marriage and that women should have monogamous relations with their husbands only. The question is then who these women are and what leads them to have sex with men.

A number of women in this group are former prostitutes. The reviews of their lives show that women enter prostitution with a high turnover rate and they frequently shift their status between prostitutes and wives or girlfriends. Their lives as prostitutes move between the two worlds: having sexual contact with men for money and developing commitment with men for family-building. Most prostitutes expect to have a family when they have earned enough money or they have met someone to live with. However, often their previous background as prostitutes creates weakness in their relationships with men, thus, women who have once worked as prostitutes are likely to move out of prostitution to become wives or girlfriends, and to re-enter prostitution after their relationships are terminated several times before they actually retire from prostitution.

Some of these women currently work in various kinds of indirect prostitution which have been developed as being closer to men's relationship with girlfriends, not prostitutes. For instance, some men prefer to pay for sex with restaurant waitresses because their relationship with this group of women is close to that with girlfriends. Unlike the usual habit of visiting brothels with friends, men who pay for sex with waitresses usually visit the women alone, which is more or less as if they are dating girlfriends. Despite the fact that they are required to pay for the relationship, some men do not perceive their relations with this group of women to be a kind of prostitution. Furthermore, not all waitresses take men for money which makes it difficult to identify whether or not women in this group are prostitutes.

The non-paid partners of men also include several kinds of women who are financially dependent on men for the continuation of their relationship. For instance, second wives, 'kept partners' (see definition in Appendix E), or casual lovers are known to be the sexual partners of married men. They demand financial support from their boyfriends to maintain the relationship which is usually more than a single contact and may develop into a long-term commitment.

Some single women may have sex with their boyfriends because they expect to marry or to live with their boyfriends in the future. While some women have no difficulty in forming a marriage with boyfriends with whom they have had premarital sex, others

have difficulty maintaining their relationship with boyfriends once they have had sexual intercourse. Some men do not continue the relationship with these girlfriends since they perceive that these women may have had sexual relations with other men as well.

CHAPTER 7
Attitudes and Beliefs about Sexuality

Sexuality which is defined as the recognition or emphasising of sexual matters (*Macquarie Dictionary*, 1985) can be perceived differently according to individuals' socio-cultural background. People in the Upper-North region once believed that mere physical contact or an intention to have physical contact with the opposite sex implied sexual misconduct. Different perceptions of people regarding sexual matters raise concerns about how people in the rural areas who mostly lack formal education perceive sexuality: what does it mean to them, what do they think about it, how do they learn about it and what kind of information is available for them in the rural areas? This chapter explores the attitudes and beliefs of Thais about sexuality based on the literature and the fieldwork data of this study. Their beliefs about the effects of contraceptive methods on sexuality and their sources of knowledge about sexuality are included.

The second part of this chapter explores some operations suggested by a number of informants as being used to sexually please their female partners. Some men have operations involving minor surgery of the penis as ways to enhance sexual pleasure. Although some women also have sexual operations, their use is more likely to be associated with sexual hygiene than the enhancement of pleasure. However, little has been documented about these male and female sexual operations; knowledge about the practices was first gained during fieldwork. Much information was later obtained from the historical and medical texts to document the significance of the practices. Lastly, the prevalence of STD and beliefs about self-treatment are explored.

7.1 TRADITIONAL BELIEFS ABOUT SEXUAL ENGAGEMENT

From a literature review, knowledge about how people in the rural areas of Chiang Mai perceive sexuality can be summarised as follows.

7.1.1 Effects of Magical Powers

The use of charms and amulets as magical protection against danger and misfortune, and also to bring love, luck, and power is popular among Thai men from every part of the country (see Anuman Rajadhon, 1964; Terwiel, 1975; Friedman, 1977). Many young men in the rural areas seem to feel insecure during the time of courtship. To increase their chance of winning a woman, they may practise magical spells or apply magical powder, lip balm, or love potion to increase their confidence in approaching a woman (Giles, 1954; Thitsa, 1980: 21). Tattooing is another way for men to enhance their magical power. Young men are motivated to have a tattoo for many reasons: to show that they are grown up and that they have bravely faced the painful process, to increase their power and charm, to be as courageous as their friends, and to impress the women.

Northern men once favoured tattoos which turned parts of their body dark. It was claimed that several decades ago northern women were only interested in men with this kind of body tattoo (Terwiel, 1975: 85; Turton, 1975: 262; Mougne, 1981: 414).[1] However, the practice became obsolete when northern men with dark body tattoos were ridiculed by people from other regions who visited Chiang Mai (Potter, 1976: 106). Although the traditional dark body tattoo has become rare, beliefs about the magical power of tattooing remain, especially among men of low socio-economic status who are inclined to have tattoos for magical power (*Siam Post*, 13 February 1994: 13-20; see also case study number 5 in Appendix D about the popularity of tattooing among prisoners).

Young single women are supposed to be passive and modest, and they do not usually practise magic. The magical practices of women are usually reports from older women who are married but feel that they are no longer the favourite of their husbands, or from young women such as the second wife who tries to secure the love of her husband. A woman may make a magic spell by mixing her vaginal secretion in the food given to a man who then reputedly loses interest in other women except herself (Terwiel, 1976: 144; Thapthong, 1993: 180-183). A man who consumes food or drink which contains the vaginal secretion also loses his power and consequently comes under the control of the woman who casts the spell (Nimmanhemin, 1987: 258). A similar belief about the magical power of the vaginal secretion is reported among prostitutes: to attract clients, some prostitutes sprinkle water which contains vaginal secretion at the door posts to induce men who come near the door to visit them regularly (Terwiel, 1975: 145).

7.1.2 High and Low Dichotomy

Thai people have a general belief about the appropriateness of the high and low position of the body parts; for instance, the head has the highest status of the body and should not be touched by anyone, especially not by people who are younger. The pillow has a high status as it is used to support the head so it should not be used to support the low body parts like feet or buttocks. Men, especially those who wear magical amulets, do not go underneath the clothes-lines that women use to hang their underwear or else they may have ill-fortune. Similarly, men's clothes cannot be washed together with women's lower clothes like skirts, sarongs or underwear. Some anthropological studies claim that men sleep to the north of their wives and are superior to women in the position they take in coitus. Only men are in control of coitus (Davis, 1974: 12-13; Terwiel, 1975: 154).[2] Men who do not follow the customs will lose their power, and spiritual and sexual potency.

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1. Several photos of northern men with dark body tattoos from the old time can be seen in Lagirarde (1989). Men with magical tattoos take several vows of abstinence after tattooing; abstaining from affairs with wives of other men is included (*Siam Post*, 13 February, 1993: 15).
2. The term 'north' in Thai language also means 'superior' or 'above'. To sleep to the north of the wives implies the superiority of men.

7.1.3 Anatomy and Physiology of Sexual Act

It is unknown how people in the village who receive no formal sex education perceive coitus and the sexual act. According to the Thai traditional medicine, 42 components of the body are classified as elements which cause diseases. They include 20 earth elements, 12 water elements, six air elements, and four fire elements which are tied up with *sen-en* or tendons (Mulholland, 1979: 90-96). However, none of these elements is described as causing sexually transmitted diseases even though they have been known as common infections among Thai men for a long time (see Bamber, Hewison and Underwood, 1993). Posture including the act of sexual intercourse is believed to be a function of the tendons as explained by some people. For instance, to the question asked about coital frequency, a female respondent answered that she did not have frequent coitus because her husband's coital tendons were damaged since he was handicapped from polio at an early age; hence, she was required to be on top for sexual intercourse. According to a general belief, some women who had undergone sterilisation were likely to be obsessive with sexual desire after the operation because *en-dee* or the good tendons which usually suppress the sexual desire of women may be cut by accident. The sexuality of the women became unbalanced and was left to be controlled by *en-hai* or bad tendons only: thus, some women were perceived to be promiscuous because of sterilisation. The belief in the control of sexuality by bad and good tendons is related to the extensive beliefs of the people about the effects of contraceptive methods on sexuality as described next.

7.1.4 Pollution of Sex

Apart from the beliefs that vaginal secretion has a magical power over men, there is a general belief that seminal fluid is polluting. Seminal fluid or *naam asuchi* in the Thai language refers to fluid of impure desires or dirty fluid (Rhum, 1987: 188). In a Buddhist belief, people who can restrain their impure desires such as Buddhist monks or restricted Buddhists can abstain from sexual engagement. Some husbands and wives may abstain from sexual intercourse on Buddhist holy days (Terwiel, 1975: 154).[3]

There is a general belief that women are polluting during the menstruation period. Sexual intercourse with menstruating women is forbidden since it may cause physical harm to men ranging from localised inflammation to leprosy (Mougne, 1978: 71), or spiritual defilement by destroying any magic they possess (Terwiel, 1975: 93). It may also cause harm to women because menstruation is the period when the woman's womb is open and coitus during this period may result in the birth of unhealthy children

3. There are four Buddhist holy days per month on average. A headman's wife in her 30s said that she abstained from sexual intercourse on every Buddhist day and also on the days of the week on which she and her husband had been born, e.g. Monday and Tuesday, which allow them only a few days a week for sexual intercourse. However, occasional sexual abstinence much depends on each individual's beliefs and cannot be taken as a general practice among Buddhists.

(Terweil, 1975: 154; Mougne, 1981: 101). Menopausal women are no longer a danger for men not only because they lose their physical attraction but also because they have stopped menstruation (Terwiel, 1975: 210).

Although there is a general belief that seminal and vaginal fluids are dirty, a number of men and women were engaged in sexual practices which seemed to be in contrast with their general belief. For instance, as shown in Appendix C, some prostitutes reported that their clients often asked for fellatio, but most of them declined to practise it. Various kinds of sexual practices were reported in a national survey of 2, 801 men and women aged 15-49 which was conducted in 1990. About 15 per cent of men and women with sexual experience reported having ever had oral-genital sex. About six per cent of them had oral-genital sex in the previous month (Sittitrai et al., 1992: Tables 3-33, 34). However, this survey information is insufficient to provide further details such as type of partners with whom these sexual practices were performed, or attitudes to the practice.

7.2 SOURCE OF KNOWLEDGE ABOUT SEXUALITY

Many young men learn about sex by having their first experience with prostitutes: however, apart from this, little is known how people in the village gain knowledge about sexuality. From information gained during my stay in the village, it seemed that people learnt about sexuality differently from generation to generation. Among those from the older generation, sex was a taboo subject. Parents often told their children that they came from a bush or from a bamboo stalk, avoiding discussion of sexual intercourse. Although discussion of sexual matters was forbidden in the old times, an exception was made when the subject was expressed in public in the form of entertainment such as folklore and local songs. Several kinds of northern songs and dances are performed for special occasions such as house warming or wedding parties. While many local songs simply describe the beauty of nature or general life of the people, some songs deal openly with sexual life and coitus.[4]

In the younger generation, those who are students receive sex education after grade 6. The information given includes knowledge of male and female anatomy, menstruation and conception, pregnancy and contraception, AIDS/HIV and prevention. However, most students claimed the sex education at school is conservative, like taking a biology

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4. Although the performance of local songs is becoming obsolete, we attended a performance of local songs (*saw*) during a field survey in village 4. For a house warming party, the owner of the house organised one for their guests. The audience who were men and women of all ages were entertained with descriptions of sexual matters in the songs. A large bird puppet with an oversized penis was placed in the centre of the garden where the songs were performed: however, the purpose of the display was not clearly understood. We were only informed by the local people that it was a tradition to have this kind of puppet for the performance of *saw kep het, kep nok* or songs of mushrooms and birds taking (see information about these local songs in Payomyong, 1986). Sexual matters are explicitly described in many traditional Lanna folktales (see institute of Social Research, 1989).

class. Their knowledge about sexuality was mostly obtained from reading or discussion with friends.

Moderator: Do you discuss with friends about sexuality?
1st student: We often gossip whether or not this or that woman is still a virgin..
Moderator: How do you know?
2nd student: Those with sexual experience have big boobs and wide bottoms...(laughs)..
3rd student: Men can tell. They are the experts.
Moderator: What did your male friends say about this?
1st student: They said virgin women have tight vaginas which makes intercourse painful with bleeding.
Moderator: Do you feel embarrassed discussing this with male friends?
Several students: We only discuss it openly among a few close friends.
Moderator: How did your get information about sexuality?
Several students: From magazines and newspaper, the sex column one. We are curious sometimes. We flip to other pages when people walk by...(laughs).

Rural village, female students

In response to questions asked about sources of sex information, 77 per cent of men and 17 per cent of women reported that they had obtained knowledge about sex from some sources. Men were four times more likely than women to answer that they had received knowledge from some sources (risk ratio=4.49, 95%CI=3.51, 5.71). Among those reported as having received sex information, 93 per cent of men and 22 per cent of women said they discussed with friends to obtain the knowledge. About 81 per cent of men and 32 per cent of women said reading materials like magazines and newspapers provided them with the knowledge. About 78 per cent of men and 11 per cent of women claimed their knowledge about sex came from watching movies and videos. About 54 per cent of men and only seven per cent of women said that they received sex education from the radio or television programs. Regarding attitudes about sex education, three questions were asked. Men and women gave similar responses as shown below.

Table 7.1 Per cent distribution according to attitudes about the provision of sex education

	WOMEN			MEN		
	Agree	Disagree	Don't know	Agree	Disagree	Don't know
Women lack source of knowledge about sexuality.	45	38	17	60	34	6
Women should be provided with knowledge about sex before marriage	65	22	13	62	28	10
Thai people need access to sex education	68	18	14	77	13	10

Note: Total men=293, total women=326.

7.3 CONTRACEPTION AND SEXUALITY

Various kinds of contraceptive methods have become popular in Thailand since their introduction in the early 1970s. Despite their convenience and high efficacy, side effects are the most common reason women give for discontinuing the use. While many studies place emphasis on the possible associations with long-term medical conditions, less attention is paid to side effects that are not considered to be important such as weight changes, physical or emotional discomfort, and changes in sexual desire. It was found in this study that contraceptive methods for spacing or terminating of childbearing have strong effects on people's beliefs about how sexual needs may have changed after adopting contraception.

7.3.1 Contraceptive Use Prevalence

The contraceptive use prevalence in Thailand increased from 53.4 per cent in 1978 to 70.5 per cent in 1987. In several large-scale surveys of currently married women aged 15-44 practising contraception between 1978 and 1989, the use of the pill and female sterilisation consistently ranked first followed by injection, intra-uterine devices, male sterilisation and other methods. The use of pills has been stable at around 20 per cent since 1978. Female sterilisation nearly doubled within a decade from 13 per cent in 1978 to 22.6 per cent in 1989. Contraceptive injection was 9.3 per cent in 1989 which was twice the 4.7 per cent in 1978 (Leoprapai and Thongthai, 1989: Table 4; National Statistical Office, 1992: Table 10).

All currently married men and women in this study were asked about the contraceptive method that they used most last year. Among 99 pairs of husbands and wives who were both interviewed, only the wife's answer was taken if the answers given were different. Only five out of 99 pairs of couples gave different answers about their method of contraception. As shown in Table 7.2, about 80 per cent of currently married men and women reported using contraception last year. The high contraceptive use prevalence may be for two reasons: first, the survey is over-represented by married men and women aged over 30 who were likely to practise contraception; secondly, this high prevalence probably reflects the substantial use of contraception among people in Chiang Mai as mentioned in Chapter 1. The different ranking of the methods reported by men and women reflects that most men reported the methods used by their wives who are a few years younger than them. Thus, the pill, not female sterilisation, ranked first in the men 's reports.

Table 7.2 Per cent distribution of contraceptive methods used most last year by currently married respondents by sex and age

	Men				Women			
	15-29	30-39	40-49	ALL	15-29	30-39	40-49	ALL
No method	16	12	15	14	21	13	23	17.5
Pill	53	43	20	36	45	25	13	26
Injection	25	18	13	17	25	19	19	20
Female sterilisation	6	24	47	29	9	40	37	32
Male sterilisation	0	1	3	2	0	1	4	2
Condom	0	1	1	1	0	0	3	1
Intrauterine device	0	1	0	0.5	0	2	0	1
'Safe' period	0	0	1	0.5	0	0	1	0.5
Total percentage	100	100	100	100	100	100	100	100
Total number	32	91	71	194	56	118	75	249[a]

[a] Missing cases=2.

Note: Among 99 couples of whom both husbands and wives were interviewed, only the wives' answers were selected when answers from husbands and wives were different.

7.3.2 Beliefs about the Influence of Contraception on Sexuality

The effect of contraceptive methods on libido has been extensively documented. In a survey of 3,452 currently married women aged 15 to 44 practising contraception in Thailand, 24 per cent reported decreased sexual desire, 33 per cent had decreased coital frequency, and 12 per cent had decreased sexual satisfaction after the use of contraceptive methods. Only two per cent of them reported increased sexual desire, five per cent increased coital frequency and 10 per cent increased sexual satisfaction after the contraceptive methods were adopted (Pattarawanit, 1990). However, this study was unable to rule out women's age and marital duration which are associated with decline of sexual interest.

One of the occasional effects of oral contraceptives is decreased sex drive or loss of sexual desire. Although some couples may enjoy sexual intimacy after using the pill, some women who know their pattern of usual sexual response are likely to recognise the loss of desire after the use. Decreased libido may occur from decreased levels of free testosterone caused by oral contraceptives (Hatcher et al., 1994). Some women on progestin-dominant, low-dosage estrogen pills may lose sexual desire, reach orgasm less easily and complain about dry vagina and less sensation in the vulva. Those taking pills with high doses of estrogen may be bothered with increased vaginal discharge from the effect of estrogen (Bell, 1992: 284). The decreased libido caused by oral contraceptives was brought up by a participant in a group discussion who claimed that she was sensitive to oral contraceptives and, at age 30, did not feel like having sex after taking the pill.

Other participants also claimed that they had the same experience but they were not sure whether their decreased feeling for sex was the result of the pill or not. It is important to point out that Thai women in the rural area have been receiving low-cost high-dosage oral contraceptives for a long time. To promote the use of oral contraceptives in Thailand, women take pills without prescription and those in the village usually receive free oral contraceptives distributed by the Ministry of Public Health. However, many Thai women usually receive high-dose oral contraceptives which may not be suitable for them to use (*Bangkok Post*, 12 June 1995). The speculation that oral contraceptives may lead to diminished libido among women is yet to be determined.

The users of intra-uterine devices complained that the device created discomfort and caused painful intercourse so the method is not popular.

1st man: The doctor told my wife to use intra-uterine device but it was not convenient at all. It is unnatural and also painful. You feel like having a minor cut on the penis. The thread that is attached to it is very irritating and causing pain.
2nd man: It makes you lack feeling.
3rd man: But the doctor told me that it is good to use intra-uterine device.
2nd man: No, don't listen. Believe me, I had the experience before. I just have a daughter this year. To cut the problem of using contraception, my wife will have a sterilisation after she bears the second child in a year after next.

Urban village, married men

1st wom: Intra-uterine device is not a popular method.
2nd wom: One can not work hard after having it.
3rd wom: I had it for seven months but had to take it out.
Moderator: For what reason?
3rd wom: My husband complained that it made the sexual intercourse painful just like what other people said.

Rural village, married women

The use of Depo-Provera or injectable progestin is another popular method other than the pill for spacing births. However, a number of women said that amenorrhoea and weight gain are the two major side effects that make its use less appealing. While amenorrhoea may be an advantage for some women, others felt that the inability to dispose of menstrual blood is unhealthy since polluted blood is accumulated inside the women's bodies. About 27 per cent of all women reported having experienced some kind of abnormal discharge or menstruation. They described the problems as too much discharge (6%), coloured or odorous discharge (7%), irregular menstruation (5%), amenorrhoea from injection (3%), and dysmenorrhoea (6%). No participant in group discussion associated contraceptive injections with sexual change.

In all group discussions of married men and women, many people believed that male and female sterilisation changed sexual desire: usually, it decreased in men and increased in women. After vasectomy, men's sexual desire was likely to diminish since they believed that the tendons which control the sexual act have been cut: only a few men have more sexual desire after sterilisation. Observations from friends or animals were cited as good

examples of sexual impotence after male sterilisation. They claimed that sterilisation is not suitable for men not only because they could not work hard after the operation but also their wives' sexual desire may be out of control if men became impotent.

1st man: From what I heard, men have no desire left after sterilisation. Half of the feeling is gone. Their energy for sex reduces by half.
Headman: Do you believe that male or female sterilisation would affect sexual life?
2nd man: It depends. Some may or may not have such experience.
3rd man: But remember that teacher? He doesn't have any feeling left after sterilisation.
4th man: Also in Ton's case, what happen to him is real.

Urban village, married men

Headman: Is sterilisation good?
1st man: It depends on whether men or women have it done. If men do it, they cannot work hard and they may be impotent.
2nd man: I wonder - can it erect after sterilisation?
3rd man: A friend of mine had it done and his genital was atrophied right after the operation. He had no feeling left for sex. But another friend becomes more sensitive, he had an affair with a young woman after sterilisation.
Headman: Probably the bad tendons were cut.
2nd man: We have to be very careful with male sterilisation. Let's say if we turned 40 and became impotent from sterilisation, what can we do if the wives have the desire? How can we help? How scandalous would it be if the wives had an affair with younger men [because the husbands were impotent].

Urban village, married men

Another theory explained why men's sexual desire may increase after sterilisation. With lack of knowledge, people were afraid that men might not be able to ejaculate the seminal fluid after sterilisation. Sexual desire of sterilised men may increase since the seminal fluid cannot be released from the reproductive system: therefore, their sexual tension would accumulate.

1st man: Like sterilisation in cattle or buffaloes, their penile tendons are cut.
2nd man: It is different in humans. Only sperm ducts are cut, not the tendons.
3rd man: Only the ducts which contain sperms are cut.
4th man: I see. Cut the ducts inside the scrotum, right.
1st man: Can one ejaculate after that?
2 nd man: It will be the same.
1st man: Does it take longer time though?
2 nd man: Everything is the same. Only the ducts guiding the sperms are cut.

Rural village, married men

Moderator: Why is male sterilisation not popular?
1st wom: Men are selfish.
2nd wom: Men could not work hard after sterlisation.
3rd wom: Yes, it is neccessary for men to be able to work hard.
4th wom: People say men could not ejaculate after sterilisation, isn't that true?
3rd wom: I don't know. My husband does not have sterilisation but he could not ejaculate the fluid. People say some men would be more sexually active after sterilisation.
2nd wom: Yes, I have heard also that men could not ejaculate the fluid after sterilisation. Then, their sexual desire would increase.
4th wom: I think it all depends on each individual's heart. It is not caused by sterilisation.

2nd wom: Just observe when we make love with husbands, they finish after ejaculating the fluid. But sterilised men cannot do that. Only clear slime, not seminal fluid, comes out.

1st wom: Like that woman's case, she said her husband can no longer ejaculate the fluid after sterilisation. Only slime comes out.

Urban village, married women

Diminished sexual desire may occur in women after sterilisation but this was perceived to be ordinary because women usually have less sexual desire than men, especially at old age. Men only feared that some women might have excessive sexual desire after sterilisation as happens with a few men: however, unlike the case of men, it would be embarrassing if women became obsessive with sexual desire. A different opinion was given by women who believed that the change in women's sexual desire after sterilisation was facilitated by intimacy with men other than their husbands.

Headman: What happens to women after sterilisation?

1st man: Their feeling definitely becomes slower because they have been sterilised already. Just like the way the dogs or the pigs are sterilised.

Headman: Have you heard people say that women who have sterilisation at young age would have excessive desire?

Several men: Of course, it happens like that.

Headman: Would they have higher sexual desire and commit an affair?

Everyone: Definitely.

2 nd man: This is the reason why the doctors do not allow women to have sterilisation at young age.

3 rd man: True. Like brother Kam's wife, she was not allowed to do it because she is only 19.

4 th man: No, she should not have it yet. It's better for her to take pill. If she had it at this young age, her husband would not be able to handle her sexual desire. She would become very promiscuous.

Urban village, married men

1st wom: Old people warn us not to get sterilisation.

Moderator: Why did they tell you like that?

1st wom: They said that *en-hai* [bad tendon] may be disturbed....(laughs)...we are very afraid that this might happan after sterilisation.

2nd wom: Yes, we all are really afraid...(laughs).

Moderator: So people believe about it.

3rd wom: Yes, old people often say to us like that. They say 'don't take sterilisation, *en-hai* may be stimulated' [agreed by everyone].

Moderator: Is it true though?

3rd wom: I don't think that it is true. Well, what do you think? You have some medical knowledge, can I ask for clarification whether *en-khan* [itchy tendon] may be disturbed during sterilisation?

Moderator: What is *en-khan*?

Everyone: (laughs)....Don't you know? *En-khan* is *en-hai*. They are the same.

Urban village, married women

Moderator: Do women change after sterilisation?.

1st wom: It depends on their hearts. Normally, they are not itchy for it before [an urge for women to have an affair with men other than their husbands].

Moderator: Why do some women change after sterlisation then?

1st wom: They want to try new thing.

2nd wom: I don't think so. I think they may be influenced by the changing environment. They don't have any worry after sterilisation. All children have grown up. They lose self-control when men flatter that they are pretty. Also their economy has improved. In the past, women used to spend most of their time taking care of children. They did not have time to look after their appearance. The kids go to school at very young age these days so women have time to put on make-up and to go flirting. They commit an affair with men who flattered them.

Rural village, married women

7.4 TRADITIONAL PENILE OPERATIONS

During the exploration phase of fieldwork, several kinds of sexual operations were mentioned by chance. For instance, some prostitutes claimed that many of their clients had an operation involving minor surgery of the penis to enhance their sexual pleasure: however, these operations may lead to condom break (see Appendix C). From fieldwork data and literature review, several kinds of penile operations, which are divided into surgical and non-surgical types, were found across many areas. The surgical type includes penile pearls and circumcision. The historical literature suggested that folk surgery to implant a hard object in the penis was a common practice for men in Southeast Asia between the fourteenth and seventeenth centuries (see Brown, Edwards and Moore, 1988; Reid, 1988: 146-150). The practice is frequently described as intended to sexually please women. However, most historical reports give deficient information. They describe the practice as having occurred only in the past: on the contrary, without any link to historical knowledge, a small number of reports in the medical journals suggest the same practice emerged among men in Southeast Asia only after the Second World War. Thai men are often cited as adopting the practice (Sundaravej and Suchato, 1974; Nitidandhaprabhas, 1975; Bork and Brauninger, 1985; Norton, 1993). It is hoped that the following exploration of these traditional sexual practices will provide general views about male and female sexuality in the context of their own culture.

7.4.1 Penile Pearls

The penile pearl is a piece of pea-sized hard round bead implanted into the superficial fascia of the penile skin.[5] The bead is permanently implanted and requires an excision to remove it. The term 'penile pearls' or in Thai *fang-muk*, 'pearls implanted', is known among many Thai men of low socio-economic status. In nine focus groups and 56 in-

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5. Most beads are made from the bottoms of glass bottles, but other objects such as stones, bullets, grains of rice, plastic beads, pearls, jewels and polished pieces of toothbrush handles are said to be used (Nitidandhaprabhas, 1975; Sundaravej and Suchato, 1974; Bork and Brauninger, 1985; Norton, 1993). A Japanese fisherman with a penile pearl said that the nodules made of glass fragments from World War II aircraft had been fashioned because they are particularly suitable to polishing into smooth nodules (Cohen and Kim, 1982). Photos of men with penile nodules can be seen in many sources (see penile nodule on the ventral aspects of foreskin in Lim et al., 1986: 123; radiogram of the pelvis of men with penile pearl in Sundaravej and Suchato, 1974: 454).

depth interviews with military conscripts in Chiang Mai and Maehongson provinces in Upper-North Thailand, *fang-muk* and several kinds of sexual operations were regularly mentioned and have been confirmed by interviews with prostitutes (Bond, 1994: 5). Painful intercourse with men with penile pearls is one of the reasons that prostitutes may refuse to take such clients (Sawaengdee and Isarabhakdi, 1990).

7.4.1.1 History of Penile Pearls

The practice of a penile incision is documented as having occurred in Southeast Asian countries for centuries as shown by penis balls represented in a *lingam* of the fifteenth century temple Candi Sukuh in central Java (Reid, 1988:151). From the existence of a bronze dog with penis pin obtained in Southeast Asia which may be the oldest reference, this practice may have dated back to the fourth century (Brown et al., 1988:6). The oldest written reference to the practice is in the *Kama-Sutra*, the Hindu treatise written in the sixth century. It suggests that men in the Southern countries adopted this practice as these men believed that true sexual pleasure cannot be obtained without perforating the penis. Various substances in a variety of shapes may be put in the perforated penis to increase the penile size and to arouse women (Vatsyayana 1982:180-182).

Although the practice dated back to the sixth century, most of the written evidence suggests that the penile operations occurred in Southeast Asia in the fourteenth to the seventeenth centuries, the period when many Westerners made their first voyage to Southeast Asia. It was suggested that the practice was widely distributed among men in Thailand, Burma, Indonesia, Malaysia, and the Philippines.[6] In Siam which is Thailand's former name, an overview of the ethnographic evidence suggests that the penile operation dated back to the late fourteenth century as noted by the Chinese, the pioneer foreign explorers to Siam.

> (in 1392)...In Siam (Hsien-lo) the penis is slit for the insertion of jewels that indicate wealth and position..
>
> Ploss et al. 1927 cited in Brown et al., 1988: 52

> (in 1433)...when a man has attained his twentieth year, they take the skin which surrounds the *membrum virile*, and with a fine knife... they open it up and insert a dozen tin beads inside the skin; they close it up and protect it with medicinal herbs...They [beads] look like a cluster of grapes...they specialise in inserting and soldering these beads...they do it as a profession. If it is the king....or a great chief or a wealthy man, they use gold to make hollow beads, inside which a grain of sand is placed...They make a tinkling sound, and this is regarded as beautiful...The men who have no beads inserted are people of the lower classes...
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> Ma Huan 1970: 104

The practice of penile incision may have been continued in Siam for a few centuries. In 1511, it was similarly suggested that the people of Siam wear bells in their penises. In

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6. Most of the written histories about this practice are very old documents, and only a few primary sources were seen. An overview by Reid (1988: 146-150) and an annotated bibliography and overview by Brown et al. (1988) gave rich information about the historical perspective of the practice.

contrast to the earlier reports, it said that the practice is forbidden to the king and religious people (Gulvano, 1905 cited in Brown et al., 1988:37). However, evidence in the late sixteenth century suggests that the practice was adopted among the kings and great noblemen in Siam (Fitch, 1905 cited in Brown et al., 1988:35-36). At the same period, several reports suggest that non-Muslim men in Pegu (a state in Burma), Siam, and Patani[7] wear up to three balls made of gold, silver, brass or lead on their penises. Women desire men to wear them (Purchas, 1617; Herbert, 1634; Commelius, 1646: Fitch, 1905 all cited in Brown et al., 1988). As mentioned in Chapter 1, Chiang Mai was a colony of Burma for more than 200 years. No evidence is available to suggest whether the penile inserts were practised among men in Lanna or not. However, the practice may have been introduced to them as some reports suggest that the penile insert was common for Peguans or Burmese men in the sixteenth century.

A large number of reports suggest that several practices of penile inserts were adopted by men in the Philippines and Indonesia between the fifteenth and sixteenth centuries. However, these types of practices are more traumatic than the one reported as being used among the Siamese or Peguan men. Five forms involving the insertion of objects under the skin of the penis are as follows:

> (1) the objects may be bells; (2) may be small solid balls, pellets, or spheres; or (3) they may be small, solid non-spherical objects...(4) involves pins or bars inserted crosswise through the penis, often with elaboration on the ends of the bar or pin....(5) also involves a pin or bar through the penis, it holds a ring or rowel-shaped object around the penis.
>
> Brown et al., (1988:1)

No historical evidence suggests that Siamese men adopted the last two forms even though it was suggested that the last one was practised widely among some ethnic Indonesian men. In a medical survey of about 2,500 men in 1929, it was found that 60-90 per cent of males in ethnic minority groups in the Upper Mahakan (Borneo) used penis pins as aphrodisiacs (Von Kuhlewien, 1930 cited in Brown et al., 1988: 45).

The information obtained from the historical evidence is not sufficient to give the prevalence of the practices, nor is it possible to suggest how long the penile inserts have been used. Reports about the folk surgery of the penis diminish in the historical literature after the seventeenth century, and it was assumed that the practice no longer existed after that period (Reid, 1988:150). Only the fourth and the fifth type of penile inserts are reported as having appeared among ethnic minorities in Indonesia up to the present (Brown et al., 1988: 6-7; Reid, 1988: 149). Nevertheless, as found in this study along with several case reports in the medical journals, it can be concluded that the penile pearls or the second form of the above practices still exist among some Southeast Asian men, especially Thai men (Sundaravej and Suchato, 1974; Nitidandhaprabhas, 1975;

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7. A former independent state, at present a province in Southern Thailand sharing a border with Malaysia.

Bork and Brauninger, 1985; Sawaengdee and Isarabhakdi, 1990; Norton, 1993; Bond, 1994). The bell type is reported to be used by some Japanese men under the name of *rin-no-tama* which is translated from the original Chinese as Burmese bells (Bornoff, 1991:157).

7.4.1.2 Penile Pearls and Medical Concerns

Although the penile operation is believed to have originated from Southeast Asia, reports of beads implanted in the penis gained medical attention when a case study of men with penile pearls was first described in an Argentinian urological journal some decades ago (Grimaldi, 1953). Most medical reports about the penile pearls were presented in the form of case reports in the journals of genito-urology (Grimaldi, 1953; Nitidandhaprabhas, 1975; Cohen and Kim, 1982; Lim et al., 1986; Wolf and Kerl, 1991), dermatology (George, 1989; Gilmore, Weigand and Burgdorf, 1983; Sugathan, 1987) and radiology (Sundaravej and Suchato, 1974). The practice has been documented in the sexually transmitted diseases journals only recently (Serour, 1993). The penile pearl has been barely mentioned outside medical journals although brief reports were found in a newspaper (Sharp, 1994), and a book (Bornoff, 1991: 158), and brief descriptions in Philippines and Thai studies (Sawaengdee and Isarabhakdi, 1990; Bond, 1994; Imperial, 1994).

In the medical area, the penile pearl is known as the 'artificial penile nodule' which has raised two medical concerns: its being mistaken for other pathological conditions, and complications which have occurred following the surgery. Although the prevalence is unknown, but believed to be low, these artificial nodules need to be distinguished from the natural nodules which appear on the penis. An X-ray shadow of the artificial nodules may look similar to that of urethral or vesicle stones or retained bullets so they need to be excluded. Although complications rarely occurred, some men suffered from infected ulcers corresponding to the puncture sites after implantation of a foreign body (Rubenstein, Sheldon and Bethesda, 1964; Sundaravej and Suchato, 1974; Nittidandhaprabhas, 1975; Cohen and Kim, 1982; Gilmore et al., 1983; Lim et al., 1986; Gaffoor, 1989; Wolf and Kerl, 1991; Serour, 1993).

Most of the medical reports suggest that Thai men are most likely to have the penile pearls. However, the practice is also known and followed by men from other Asian countries: it is known as '*bulletus*' or bullet in the Philippines (Sugathan, 1987) and '*chagan* balls' in Korea (Lim et al., 1986). Men with penile pearls include the Japanese and Chinese (Cohen and Kim 1982; Sugathan, 1987; Bornoff, 1991), Singaporeans (Lim et al., 1986), Malaysians (Sharp, 1994), Vietnamese and Cambodians (B. Franklin and Nguyen Tran Hien, 1994 personal communication). Some recent reports suggest that non-Asian men also adopted the penile pearls, eg. Fijians (Norton, 1993), Romanians (Wolf and Kerl, 1991) and Russians (Serour, 1993).

7.4.1.3 Research Findings

Interviews and discussions with those who are familiar with the practice show that insertion of the penile pearl is an easy self-operation which is usually done among friends who may share the instruments. It entails piercing the penile skin with a sharp instrument followed by inserting beads into the superficial fascia of the penile skin. The implantation of beads may take any part of the penile skin even though the dorsum is the most common site.[8] The wound is left unstitched and a dressing is applied for a week. After healing, good beads are movable underneath the penile skin but a poor operation causes fixation of the beads from tissue fibrosis.

The piercing instrument may be a sharpened stick of bamboo or a plastic toothbrush handle. The bead is mostly made from a piece of broken solid glass cut and polished into the required shapes and sizes. Beads can be made from many other kinds of hard material as well as artificial pearls, ivory, or gems. The polished beads are soaked in antiseptic solution for a few hours before being used. Although more than ten beads have been reported by others (Anon, 1883 cited in Brown et al., 1988; Nitidandhaprabhas, 1975; Sugatham, 1987), the maximum was seven beads according to a few prostitutes interviewed in this study.

The survey findings support the claim that insertion of penile pearls or *fang-muk* is a known practice among Thais. About 40 per cent of 267 men with sexual experience reported having a friend with penile pearls.[9] Of these, seven per cent said more than five of their friends had the operation. However, these figures may be over-reported because many respondents came from the same village and some were from the same household. From the peculiar characteristics of the operation, it is likely that men with penile pearls may be known among their peers and the respondents from the same village or the same household may have cited the same persons as those known to have the operation for penile pearls.

About 44 per cent of 245 currently married women (missing cases=6) reported that they had ever heard about penile pearls. This figure may be over-reported as well: some women may report having heard about the penile pearl even though they may not know about the actual practice. Half of the women who reported having heard about penile pearls did not know why men adopted them. In other words, only 22 per cent of currently married women could state the reasons why men followed this practice. Some women may have known the reason but declined to reply, simply saying they did not know from embarrassment.

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8. The beads may be implanted in the scrotal sacs as well as reported among Filipino seafarers (Imperial, 1994).
9. Although it seems that *fang-muk* may be well-recognised, this claim is limited to the survey respondents who are men and women living in the villages only. From personal communication with many people, I found that *fang-muk* may be less known among men and women from the middle class and people in the younger generation.

Only 2.6 per cent or seven out of 267 men with sexual experience said they adopted penile pearls. The low prevalence may come from the fact that the response was obtained from the general population. However, it was not known how many men were telling the truth about their penile pearl status. Only one prevalence report was available for comparison: during ritual circumcisions of Russian adult immigrants in Israel, it was found through examination that six of 937 men 18 years of age and older, or a prevalence of 0.64 per cent, had penile pearls (Serour, 1993). According to most informants and the information obtained from medical journals, the prevalence of penile pearls may be greater if the sample is drawn from men in a low socio-economic class such as migrant labourers, military conscripts, truckers, fishermen, prisoners and drug users. The penile pearl is not only locally known among men in the Northern region but also among blue-collar men from all parts of the country. One informant who worked as a fisherman in the Southern province for a few years claimed many of his friends who were fishermen adopted the penile pearls (case study 5 in Appendix D).

One of the seven men with penile pearls found in this study said he had the operation when he was in prison. Another two said they adopted the operation while working as manual labourers in Middle East countries, they claimed it was a common practice among overseas workers. The rest did not identify the place of operation. From in-depth interviews for exploration, a group of three heroin addicted men in their early twenties had an operation for the penile pearls on the day of the interviews at the Drug Treatment Centre. As shown in Appendix C, all except 12 brothel-based prostitutes had had clients with penile pearls. Most claimed to find men with penile pearls every few weeks. Nevertheless, the prevalence of men with penile pearls cannot be fully validated since it was not known whether or not these men with penile pearls were the same persons who may frequent prostitutes.

Of seven men with penile pearls, three were single and the rest were in their first marriage. All but one had less than primary education: only one man with a penile pearl had received a diploma. Five of them had beads made from a piece of solid glass taken from the bottom of a bottle or a glass. The other two had beads made from pearl or ivory. Only one man implanted the glass bead in the penis by himself and the rest were assisted by friends and had the operation together with friends.

7.4.1.4 Reasons for Penile Pearls

The common explanation of penile pearls in both medical and historical literature is a psycho-sexual reason for enhancement of sexual pleasure in women by 'direct mechanical stimulation for partners during sexual intercourse' (Sundaravej and Suchato, 1974: 454); 'enhance coital excitement and orgasm of the sexual partner during sexual intercourse' (Lim et al., 1986:124); 'increased potency...because they are the product of the vulviform

oyster...enhanced erections' (Bornoff, 1991: 158) and; 'enhance their attractiveness to the ladies....increase the penis size....a sign of manhood' (Imperial, 1994: 11).

From an analysis of more than a hundred related historical documents, the way Southeast Asian men inserted objects under the skin of the penis was concluded to be further evidence of the high autonomy and equality enjoyed by Southeast Asian women along with their property rights, high rates of divorce, dominant position in the family, and matrilineal kinship (Brown et al., 1988). It is also suggested that penile pearls probably are part of a common belief about body magic similar to tattooing among many Southeast Asian men. However, through lack of information from women, it is unknown whether the penile pearls are really desired by women as claimed by men. In comparison to the functionally similar type of sexual devices used in the Western countries, it is doubtful that such practices would be desirable to women.

Among women who had heard about penile pearls, 40 per cent of them believed men adopted the practice to make women *muan* or enjoy sex, five per cent said men would like to enhance their own pleasure and the rest did not know the reason. Seven men with penile pearls found in this study also claimed that they adopted the practice because they wished to facilitate sexual pleasure for women or want *phu ying muan*. In agreement with the earlier reports (Nitidanphaprabhas, 1975; Serour, 1993), encouragement by friends was cited as the main factor that made them take the operation. A few added that the implantation of pearls in the penis is a symbol of manhood just like tattooing. A few others cited boredom as another factor causing them to adopt the practice. Information obtained from a group discussion with married men aged over thirty gave a different perspective, however. Although the penile pearl is known to them, they did not recognise it as an important practice. They considered penile pearls to be common among men with excessive sexual desire or those who frequented prostitutes.

1st man: From my experience, women really enjoy it. They feel the difference. From a man that I saw, he implanted three beads, one in the front and the other two in the back. The operation would arouse the women. But men with this kind of operation are older than us, they are not from our generation.

Headman: Men with penile pearls want to try a new taste.

1st man: They want to try whether or not women would like it because the operation is special.

Rural village, rural men aged 27-41

Headman: Men who enjoy having sex with prostitutes have penile pearls. Is it true that the practice enhances the sexual pleasure for women?

1st man: I have heard people say like that. When I was younger, I had tried having sex with a rubber band on, and would say that it was quite enjoyable. I bet that penile pearls would increase pleasure even more. But some women don't like it though.

Headman: What kind of men have the penile pearls, a womaniser type?

2nd man: Only those who have excessive sexual desire.

Rural village, married men aged 34-51

It was not possible to validate the claim by men that the penile pearls truly enhance sexual pleasure for women since only three women whose husbands had penile pearls took part in the survey. Also, these women had a monogamous relationship with their husbands only so they were unable to differentiate whether or not the penile pearls enhance sexual pleasure for women as claimed. Nevertheless, the information obtained from prostitutes clarified some doubt. Most prostitutes who had had clients with penile pearls disagreed that the operation enhances sexual pleasure, on the contrary, they complained that it makes intercourse painful. Most of them would refuse to take clients with penile pearls, especially if a few beads were implanted. Some claimed they could not take any more clients after having intercourse with men with penile pearls.

Some men probably adopt the penile operation to make up for the fact that women are supposed to suppress their feelings for sexual desire or response. Thai phrases such as *keng pen mai* 'lying still like a log'; *rai arom* 'no sexual feeling'; *tai dan* 'to be blunted of sexual desire' are often used to describe the women's response during sexual intercourse. Some men probably adopt the penile pearls to provoke responses from their female partners.

All except one of seven men with penile pearls in this study had paid for sex for more than 20 times. Of these, one was a currently married man aged 31 who had paid for sex about 50 times before marriage: his last sex with prostitutes was after marriage eight months ago. Four men with penile pearls reported recourse to prostitutes between 80 and 300 times by their late 20s. Among three male respondents with AIDS (see Chapter 8), one was a single man with penile pearls. While all prostitutes claimed that penile pearls caused condom break, some men believed that penile pearls would not cause condom break since the beads are movable underneath the penile skin.

7.4.2 Male Circumcision

The association between lack of male circumcision and HIV infection has gained much attention from researchers in recent years (Caldwell and Caldwell, 1993; Bongaarts et al., 1989; Moses et al., 1994). With relatively few circumcised men available for comparison, the association of male circumcision with HIV infection has been simply overlooked in Thailand. The prevalence was found to be low: however, the information obtained from this study suggests an interesting piece of evidence about circumcision among Thai men. Some men related circumcision to enhancement of sexual pleasure just like the reason for penile pearls.

7.3.2.1 Purposes of Male Circumcision

Circumcision has been advocated for several reasons: for religious purposes among the Jews and Muslims; for cultural reasons among several African ethnic groups; for penile hygiene in a few Western countries, and for therapeutic purposes. The likelihood that

an individual will be circumcised depends on his nationality, race, religion, social class, age and attitude of the attending physicians. In general, the purposes of male circumcision may be divided into four areas as follows.

Religious or Cultural Purposes

The earliest evidence of male circumcision dates back to 3000 BC as depicted in a bas-relief on the tomb of the Egyptian King Ankh-Mahn (Bitschai and Brodney, 1956; Kaplan, 1977:4-5; Schneider, 1976 cited in Warner and Strashin, 1981: 968). Nevertheless, this schematic drawing in Figure 7.1 does not specifically suggest circumcision only. With previous knowledge about penile pearls and other kinds of penile inserts, this picture may depict the similar penile operations which were done among Southeast Asian men as well. The purpose of the practice in history is unknown even though a few assumptions have been made such as for cleanliness, for punishment or a mark of slavery by the Egyptians (see Kaplan, 1977: 4-5, Caldwell and Caldwell, 1993: note 1). It was suggested that Polynesian and Indonesian boys and adults were circumcised to facilitate coitus (Gairdner, 1949). In two recent reviews of the anthropological literature, it is suggested that male circumcision is essentially universal among men in west Africa but is absent in central east Africa and in parts of southern Africa. Information for north Africa is not available (Bongaarts et al., 1989: 374; Moses et al., 1990).

Figure 7.1 Schematic drawing of bas-relief found in tomb of Ankh-Mahor

Source: Bitchai and Brodney, 1956:

Prophylactic Purposes

Neonatal circumcision used to be a common practice in many Western countries, especially the United States. It is believed that circumcision of a male newborn shortly after birth facilitates penile hygiene and provides benefits for prevention of cancer of the penis, decreases the incidence of genital herpes in later life, decreases the incidence of sexually transmitted disease, prevents phimosis, paraphimosis and balanitis, avoids the pain and possible psychological effects of late circumcision, avoids risk associated with anaesthesia for late circumcision, and lastly avoids the cost of late circumcision (see Kaplan, 1977; Warner and Strashin, 1981). Unlike the case with adults, it is believed that the pain and irritability that result from circumcision in newborn males are restricted to the immediate time of surgery. Therefore, it is recommended that the best time to perform circumcision is during the period shortly after birth, and anaesthesia is not usually used during the operation (Warner and Strashin, 1981: 972-973).

In some cases, baby boys were circumcised because their parents were led to believe that it was desirable or they had certain beliefs about neonatal circumcision and a few incurred the displeasure of their doctors by refusing to allow the operation to be performed (Kaplan, 1977:12; Laing, 1982). An important determinant of whether a newborn male will be circumcised is the attitude of the attending physicians which influences the prevalence of neonatal circumcision in some countries (Warner and Strashin, 1981:967). However, the prevalence of circumcising newborns has been declining as a common phenomenon in the countries where it used to be widespread. In the 1970s, between 69 and 97 per cent of newborn males in the United States were circumcised shortly after birth (Leitch, 1970: 59; Wirth, 1978) but this has been rapidly declining (Fink, 1986). In Australia circumcision after birth dropped from 60 per cent in the 1960s to 40 per cent in 1977 (Wirth, 1978). In Canada, fewer than 50 per cent of newborn males were circumcised after birth and this has been declining as well (Leitch, 1970:59). In England, about one-third of men were circumcised at birth in the 1940s. By 1975 the rate had dropped to about ten per cent (Wellings et al., 1994: 308). Prophylactic male circumcision is known to be uncommon in northern European countries, Central and South America and Asia (Leitch, 1970:50).

Therapeutic Purposes

Those opposed to circumcising newborns believe that there are no valid medical indications for circumcision in the neonatal period since the foreskin would be retractable at a later age as shown by a few studies. From a review by Kaplan (1977), at birth only four per cent of newborn males would have a completely retractable foreskin and it would be still unretractable by six months of age in 80 per cent of boys, by one year in 50 per cent, by two years in 20 per cent, and by three years in ten per cent. In other words, it is suggested that the percentage of boys having an unretractable foreskin dropped from more than 90 per cent at birth to only ten per cent by the age of three. In the study by

Gairdner (1949) the foreskin was still not retractable in six per cent of children aged 5 to 13 years and could be only partially retracted in 14 per cent. Similarly, in an examination of over 9,000 schoolboys in Denmark by Oster (1968) an unretractable foreskin was found in eight per cent of five-year-olds but in only one per cent of secondary school students. Warner and Strashin (1981) suggested that most men would have a completely retractable foreskin by the age of 17. Consequently, only about ten per cent of males not circumcised at birth would eventually require circumcision at a later age. Therefore, circumcision should be performed only for specific indications when the foreskin is still non-retractable after age three rather than as a routine operation for penile hygiene.

It has been repeatedly suggested that there are no valid medical indications for circumcision in the neonatal period (Thompson et al., 1975). Parents of uncircumcised newborns should be told how to clean an unretractable foreskin of their baby boys instead. Several indications for men to be circumcised at a later age include true phimosis (the inability to retract the foreskin which results in obstruction of urinary flow), paraphimosis (the foreskin has become retracted but cannot be brought back over the glans), balanitis (inflammation of the glans), posthitis (inflammation of the prepuce), and a short frenulum (Kaplan, 1977; Warner and Strashin ,1981).

Cosmetic Purposes and Other Beliefs

Some physicians oppose prophylactic male circumcision; they suggest that circumcision should be an elective cosmetic surgery if there are no medical indications (Patel 1966; Sze, 1982). This is similar to the attitude of the French surgeons in the seventeenth century who recommended male circumcision as a practice for the sake of handsomeness (Pare, 1649 cited in Kaplan, 1977: 5). A few physicians at present also believe that male circumcision is a beautification not a necessity (Preston, 1970). Although an earlier report suggested that Australian aboriginal men were circumcised (Gairdner, 1949; Burger and Guthrie, 1974), others recalled this operation as penis subincision, not circumcision, which may be done for sexual pleasure (Basedow, 1927; Bloch, 1928 cited in Brown et al., 1988: 30-31).

Other reasons cited by parents desiring circumcision of their newborn sons include: to match siblings, friends and relatives; other relatives advised it; a women's magazine advised it; it is done automatically; to prevent masturbation; to prevent rupture; for fertility; it's required for the armed forces; it's a good and proper thing to do; it's routine where we come from; to prevent excessive crying; and to make a boy feel regular (Patel 1966).

7.4.2.2 Controversy over Male Circumcision

There have been several debates about the risks and benefits of male circumcision and the latest one is about whether lack of circumcision facilitates HIV infection. In the

study area of sexual behaviour and HIV transmission, male circumcision gained research attention in the late 1980s after a number of studies, most conducted in Africa and a few in the United States and other countries, claimed that an intact foreskin and genital ulcers are associated with HIV infection (Simonsen et al., 1988; Cameron et al., 1989: Hira et al., 1990; Hunter et al., 1993). The recent reviews of the epidemiological data (Jessamine et al., 1990; Moses et al., 1994) and ecological data (Bongaarts et al., 1989; Moses et al., 1990; Moses et al., 1994) indicate that a substantial body of evidence links non-circumcised men with risk of HIV infection. However, it may be argued that most of these studies have potential biases since no assessment has been made to determine the indirect effect of lack of circumcision, genito-urinary diseases and HIV infection.

Despite several explanations of biological plausibility (Oates 1987; Fink, 1986, 1988), how the foreskin increases susceptibility to HIV infection remains controversial (de Vincenzi and Mertens, 1994). As circumcision practices are related to factors like religion, race, social class and ethnicity which are strongly associated with sexual behaviour, the relationship of HIV infection and other STDs to lack of circumcision requires cross-cultural analysis with efforts to control for confounders such as sexual behaviour and socio-economic status (Holmes et al., 1990: 31; Moses et al., 1990: 206-207). Furthermore, a study in Gambia suggested that without physical examination there may be a discrepancy between the true and the reported status of circumcision as shown by the fact that 16 per cent of 'circumcised' men were found to be functionally uncircumcised. It was also suggested that some circumcised men may be categorised as uncircumcised owing to the length of residual foreskin (Pepin et al., 1992). In recent reviews of currently available evidence on lack of circumcision as a risk factor for STD/HIV infection, it was suggested that a control was necessary for the confounding factors. Variables related to sexual and hygiene behaviour and recruitment of a homogeneous group outside STD clinics, in which some men are circumcised and others are not, are necessary before it can be concluded that lack of male circumcision is a true risk factor for HIV infection (de Vincenzi, 1992: 15-17; de Vincenzi and Mertens, 1994). Nevertheless, Caldwell and Caldwell (1993: 822) argue that it is not possible to conduct such a study in Africa where circumcision divides along ethnic borders. They suggest the armies in the United States or Australia where the record of chancroid is available from the medical histories may be used as an alternative group for further study.

7.4.2.3 Different Kinds of Circumcision

The reasons for Thai men to circumcise were mostly eccentric as found in this study. While half of male respondents said they did not know why men have circumcision, others related male circumcision to the enhancement of sexual pleasure rather than the concurrent beliefs for prophylactic or therapeutic purposes. They claimed circumcision is a practice that sexually pleases the women like penile pearls. According to several informants, there were a few kinds of male circumcision defined as typical circumcision,

Benz circumcision, and other circumcision. The last two types were not apparently as well known as the former but the reason for adopting such circumcision is the main interest.

Benz Circumcision

The knowledge of Benz circumcision or in Thai *pha-benz* was obtained by chance when enquiring about circumcision from an informant who had witnessed several men undergo this operation while he was in prison for a year (see case study number 5 in Appendix D). The operation can be performed by friends or any non-professional persons. A razor blade is used to cut the foreskin into several segments. The word *benz* refers to the resemblance of the multi-segmental foreskin to the emblem of the Mercedes Benz car. Wound stitching is required only if heavy bleeding occurs, otherwise the wound is left open with a pressure dressing for a few weeks. The wound stitches would help also in keeping the foreskin apart in separated segments. No anaesthetic is required during the operation. It takes about two weeks for the wound to heal, if there is no infection. A hard scar will form around the glans penis which would increase the size of the penis.

The practice was claimed to be well known among prisoners, manual labourers and men who frequent prostitutes: however, the prevalence of the practice is unknown. A few questions about Benz circumcision were added in the survey questionnaires, and it appeared that Benz circumcision was less well known than penile pearls. Ten per cent of 267 men with sexual experience and 2.6 per cent of currently married women reported having heard about Benz circumcision. Two men reported having the circumcision themselves and 13 men reported having friends with this circumcision. One man had Benz circumcision as well as penile pearls. Similar to the reason for penile pearls, most of those who had ever heard about Benz circumcision claimed that men had this circumcision because women like it and women would enjoy sex. Two men with Benz circumcision were in their twenties, one was married and the other was single. The married man with Benz circumcision said he had the operation because women like it and the other said such circumcision increased sexual satisfaction for both sexes.

Typical Male Circumcision

The circumcision here refers to the universal meaning of circumcision which is the surgical removal of the foreskin of the glans penis. This circumcision is known in Thai as *khlip (hnang hum)*. About 70 per cent of men and women did not know why men have circumcision, nine per cent believed men were circumcised to increase the size of the penis[10], and about 20 per cent believed men were circumcised for one of these reasons: constricted prepuce, unretractable foreskin, Islamic religion, or for proper

10. The respondents meant that circumcision makes the glans visible and it appeared to them that this enlarged the size of the glans. They used the terms *tham hai man yai* or 'to make it big' to describe this belief.

hygiene as suggested by health staff. When men's responses are analysed, 57 per cent of men with sexual experience did not know the reason for circumcision, 17 per cent believed circumcision increased the penis size, and 26 per cent cited other reasons.

From discussions with people in the villages, it seems that the prevalence of male circumcision can be divided into the operation at birth and the operation when adult. Some people suspected that the prevalence of circumcision at birth might be higher in the last two decades owing to the intentions of the physicians in the areas. They claimed that during this period a large number of newborns were circumcised at birth without any informed consent from their parents and the reason for the operation was never known to them. One respondent whose newborn son was circumcised without his consent at the hospital six years ago complained that his son's sexual ability may be affected by the operation. When his son urinated, he observed that the urine did not go straight and he was worried that this might affect his son's sexual ability when he grows up. Similarly, many other parents found their newborn sons to be circumcised at birth without any explanation.

Adult men can be circumcised at the hospital but this is not a common practice. Only four per cent of all men aged 15 to 49 were circumcised and, similarly, only six per cent of currently married women said their husbands were circumcised. Reasons for circumcision given by circumcised men were: constricted prepuces (n=3); to make the penis bigger (n=1); as suggested by doctors (n=7); for proper hygiene or to prevent disease (n=2). Some people suggested that circumcision was not a necessity and it was rare to have circumcision at the hospitals except among those with a severely constricted foreskin at an early age. Alternately, circumcision may be done by traditional healers in the village.

Other Circumcision

There are a few other kinds of less popular male circumcision. The penile ring or *wong wan* is another operation which men may adopt to increase the size of the penis like Benz circumcision. To operate, two sides of the foreskin are cut and rolled-up into a ring shape around the glans penis. The wound is stitched to secure the position of the folded foreskin. Similarly to penile pearls or Benz circumcision, it is believed that the increased size of the glans penis would facilitate sexual enjoyment of women.

7.4.3 Non-surgical Male Sexual Operations

Some other male sexual operations do not involve surgery. To enhance sexual pleasure, *kob-ta-pae* or lamb's eyelid may be used as a temporary penile ring to be worn around the glans penis during sexual intercourse. To stimulate sexual enjoyment for women, a lamb's eyelid, including the eyelash part, is cut into a circular ring shape and is sun-dried. *Num-mun-jing-len*, lizard oil, or other types of massage oil may be applied by some men

to prolong the penile erection. Some prostitutes claimed that some of their clients probably had penile injections because they had a palpable large lump on the shaft of the penis. According to a respondent who had an injection, he paid the traditional healer 150 baht (A$9) for the penile injection about five years ago. The type of substance used for the injection was unknown.

7.5 FEMALE SEXUAL OPERATIONS

Similarly to men, women also have several kinds of sexual related practices, some of which were claimed to be used to facilitate intercourse, and others were related to women's sexual hygiene. Two types of vaginal preparations, vaginal tightening and vaginal cleansing, are suggested. Little is known about the prevalence of vaginal cleansing among Thai women. The extensive advertisement of the products in the mass media indicates a demand for the practice; or perhaps the advertisement is creating the demand. However, the use of commercial products is limited to certain groups of women: it is not known if women in rural areas undertake this practice. In Thailand where commercial sex is generally accepted, it is suspected that some women who are offended by their husbands' recourse to prostitutes probably adopt some forms of self-protection such as vaginal cleansing to protect them from STD infection.

7.5.1 Vaginal Cleansing

Douching or forcing fluid into the vagina and letting it drain back may be used for several reasons such as to prevent pregnancy, to prevent sexually transmitted diseases, or to promote proper hygiene. In the 1988 national survey of 8,450 women aged 15-44 in the United States, 37 per cent of them reported regular douching: 18 per cent of them did it at least once a week (Aral, Mosher and Cates, 1992). Douching was found to be common among women of low socio-economic status with less education (Forrest et al., 1989; Stock, 1989). The number of partners was another factor that differentiated the practice. Women with only one partner and those with ten or more partners were less likely to douche than others (Aral et al., 1992). Despite the high prevalence of vaginal douching, the reason for the practice has not been well studied. Douching is not an effective way to prevent STD: however, it has been used for a long time in the belief that the practices would prevent sexually transmitted diseases:

> ....From Ming erotic novels, men and women used to wash their genitals both before and after the coitus, and lubricants used such as agar-agar jelly covered up small wounds and abrasions on the genitals and prevented infection. Men used occasionally a cover for the top of their member, called yin-chia, though rather to prevent conception of their partner than for hygienic reasons...
>
> Van Gulik 1961:311

About 80 per cent of Thai prostitutes insert fingers to clean inside the vagina to remove seminal fluid after each sexual encounter because they believe that the practice prevents them from getting STD (Saralamba, 1987; Narongrit, 1989; Saengyai, 1991). In

interviews, all brothel based prostitutes said that after every sexual encounter they would insert their fingers to clean their vaginas to ensure that they would not be infected with an STD as well as to clean off the lubricant left from condoms. Two female informants who were not prostitutes also claimed that they always inserted fingers to clean the vagina after sex. To detect the prevalence of the practice, some questions were added to the survey to explore whether vaginal cleansing is a common practice among women generally. As shown in Table 7.3, three methods of vaginal cleansing were reported. Nearly one-third of currently married women aged 15 to 49 cleaned inside the vagina almost every time after intercourse and most inserted the fingers to clean. Some added that they inserted the fingers one inch deep or about the level of the first finger joint and others inserted the fingers until they could touch the cervix. Douching with commercial solution does not seem to be a popular method among the respondents.

Table 7.3 Prevalence according to methods of vaginal cleansing after sexual intercourse of currently married women

Ever adopted any methods or not	%	n
TOTAL	100	250 [a]
Had never adopted any method to clean the vagina	73	183
Had ever adopted one of the following three methods	27 [b]	67
Insert fingers to clean the vagina		
Always	*20*	*50*
Not often	*4*	*11*
Douching with commercial solution		
Always	*1*	*3*
Not often	*0*	*0*
Douching with tap water and plastic tube		
Always	*5*	*12*
Not often	*0.5*	*1*

[a] Missing case=1.
[b] The sum of the three methods is not equal to 27 per cent because seven women reported using more than one method.

Reasons for the practice were not asked in the survey. Women who practised vaginal cleansing after coitus might do it to prevent pregnancy. However, 76 per cent of those who used the vaginal cleansing methods had already used some form of contraception: 30 per cent were sterilised, 42 per cent used pills or injections and the rest used other methods. Some women probably adopted the practice to remove the seminal fluid as it was offensive to them. Some women said their reason was that they felt unclean after coitus. Some feared that the seminal fluid might come down and stain their clothes the following day, which would embarrass them.

All currently married women were asked if they were offended by their husbands' seminal fluid; similarly, currently married men were asked whether they believed their wives objected to the seminal fluid. Table 7.4 shows that half the currently married women said they objected to the seminal fluid, but only four per cent of currently married men believed their wives objected (risk ratio=10.9, 95% CI=5.46, 21.76).

Table 7.4 Per cent distribution according to question asked about the offensiveness of the seminal fluid

	Very much	Some	Not much	Not at all	Not sure	Total %	Total N
WOMEN - Are you offended by the seminal fluid of your husband during sexual intercourse?	9	25	11	51	4	100	250[a]
MEN - Do you think your wife is offended by your seminal fluid during sexual intercourse?	0	3	1	94	2	100	193[a]

a Missing case=1

7.5.2 Vaginal Tightening

Some studies suggested that women in African countries such as Central and Western Zaire, Zambia, Malawi and Zimbabwe insert herbal agents or substances into the vagina to enhance sexual pleasure, or to protect themselves from sexually transmitted diseases (Runganga, Pitts and McMaster, 1992; Brown, Ayowa and Brown, 1993). This practice is not universal in Africa but is relatively common among rural and poor women and prostitutes (Williams, 1993).

Similar to African women, some prostitutes in Thailand also use vaginal substances. In interviews, military conscripts from the northern region claimed that between 60 and 70 per cent of prostitutes in former days applied alum inside their vaginas before taking clients: however, the practice had declined to only about 40 or 50 per cent (Nopekesorn, personal communication, 1992). The alum douche dries and tighten the vagina: the roughness of the vagina makes intercourse more pleasurable. However, as pointed out by Nopekesorn, men are likely to acquire bruises or bleeding abrasions on their penises when alum is used, and the condom is more likely to break. Prostitutes also get abrasions inside their vaginas which possibly increase their risk of STD or HIV infection.

In Africa, putting alum in the vagina for tightening is also common among prostitutes (J.C. Caldwell, P. Caldwell and J. Anarfi, personal communication, 1993).

None of the prostitutes interviewed in this study said they had ever used an alum douche. They said alum was used only in former days to dry and tighten the vagina when many clients were taken continuously. However, 56 per cent of men who ever had sex with prostitutes reported having had sex with women who used alum. They believed that prostitutes applied alum to enhance sexual pleasure (40%), to tighten the vaginal muscles (40%), to clean the vagina (12%), and to prevent pregnancy (4%).

Some women gave a different opinion about alum douches. Five per cent of currently married women said they used alum douches from time to time for cleanliness purposes. Only one woman said she used alum douches both for cleanliness and for tightening the vagina. Another woman said she would recommend every woman to apply alum for a month after giving birth to quickly dry the vaginal secretion.

7.6 BELIEFS ABOUT SEXUALLY TRANSMITTED DISEASES

Self-treatment for STD is a known practice among Thai men who enjoy prostitute patronage. The treatments range from preventive methods such as washing the genitals or taking medicinal drugs before sexual intercourse to curative treatments such as herbal medicine, over-the-counter drugs, or self-administered injections. Others perceived alcohol, carbonated water or vinegar as good cleansers against sexually transmitted diseases, or some applied eye lotion or toothpaste to wash the penis after sex in an attempt to prevent the infection. Soda water, diuretic drugs or antibiotic capsules may be taken before or right after sex as they believed that excessive urine output would flush the diseases out of their bodies (Havanon, Knodel and Bennett, 1992:25, 35; Beesey, Atthamessara and Tan-ud, 1993; Khamboonruang et al., 1994).

7.6.1 Prevalence of STD Infection

In the survey, about half of men reported having had an STD at least once in a lifetime as shown in Table 7.5. About 25 per cent of those aged between 30 and 39 were infected with STD at least once. Among 96 currently married men who ever had STD, all except five men or 95 per cent of them said they were infected with STD before marriage only: only four men said they were infected with STD both before and after marriage. Despite the fact that about 40 per cent of men paid for sex after marriage, the low prevalence of men with STD after marriage probably shows that married men frequented prostitutes less often than single men. Among currently married men who ever had STD, the median number of infections was two: however, about 33 per cent of them were infected with STD more than twice. Only one man said he got an STD in the past year.

However, only one of the three male respondents with AIDS perceived himself as having an STD in the past year (see life histories review in Appendix D).

About four per cent of currently married women said they had ever had an STD which is close to the figure reported by men who were infected with HIV after marriage. However, the prevalence of STD especially among women may be under-reported because some people may have an STD without experiencing any symptoms. A number of Thai women were found to be infected only when they presented themselves for prenatal care, in which a blood test for syphilis is usually taken to prevent the transmission of syphilis to the foetus.

Table 7.5 Prevalence of STD in the lifetime of men by age and marital status

	All men		Single men with sexual experience		Currently married men	
	%	n	%	n	%	n
Never had an STD in the lifetime	55	162	53	31	51	98
Ever had an STD in the lifetime reported by age group						
15-29	10	28	19	11	8	15
30-39	23	67	25	15	25	49
40-49	12	36	3	2	16	32
TOTAL	100	293	53	59	49	194

7.6.2 Preventive Methods and Treatment

Because very few Thai men used condoms with prostitutes until the outbreak of AIDS, many of them were once infected with STD, and self-treatment has been a common practice. Among 131 men who ever had STD, 45 per cent said they had taken medicines including antibiotics, antidiuretic and herbal tablets to prevent themselves from getting STD. About 88 per cent of those with STD said they usually forced urination right after intercourse with prostitutes as they believed that the practice would clean out the diseases. About 16 per cent of them adopted *coitus interruptus* to protect themselves from STD infection, and another 20 per cent believed that genital cleansing with solutions such as soda water or hydrogen peroxide protected them from STD. However, the reason for the belief that *coitus interruptus* might prevent an STD infection was not well explained. A similar belief about *coitus interruptus* also applies to AIDS prevention as shown in Chapter 8. Note that sexually transmitted disease is referred to as 'women's diseases', which reflects the general perception that prostitutes are the source of STD infection.

Headman: How can you be sure that you would be safe from getting a women's disease when you *aeo sao*?

1st man: In the past 4-5 years ago, nobody used condoms.

Headman: They were not afraid of anything.

2nd man: When you get an ulcer, it was so simple to treat. You just clean it and it's gone.

Moderator: Would urination right after sex flush out the germs?

Everyone: Of course.

3rd man: Also, you have to clean your genital. Take a bottle of water or tooth paste to clean it.

Headman: How come not many men are found to be infected with syphilis or chancroid these days?

Everyone: Unlike AIDS, these diseases can be treated so easily. You just need some Kanamycin shots. One can be instantly cured within seven days.

Urban village, married men.

7.7 DISCUSSION

The body of knowledge about sexuality among people in the rural areas is formed by a mixture of traditional beliefs, taboos and peer influence. Men are regarded in these relations as being superior to women and are in control of sexual relations which are perceived as taboo and polluting. Beliefs about the effects of contraceptive methods on sexuality provide a good example of how the peasants perceive sexuality. There is a general belief that nature makes men obsessive and women suppressive of sexual desire, but these tendencies may reverse as a result of male and female sterilisation. From lack of anatomical knowledge, it is believed that coitus is a function of 'bad' and 'good' tendons which are operating in opposite directions between men and women. In a defective female sterilisation, the women's good tendons may be cut: therefore, women would be left with excessive sexual desire from the dominant function of bad tendons. Parallel, but opposite to this belief, is the view that men who undergo sterilisation may experience sexual impotence if their good tendons are cut by accident. Although both men's and women's sexuality may be changed after sterilisation, sterilisation is perceived to be more suitable for women than men. Some wives apparently commit adultery if their husbands become impotent after sterilisation. They can justify this, at least to themselves, because it is shameful if husbands are unable to satisfy their wives' sexual needs.

Several kinds of traditional male and female sex-related operations were given attention in this chapter because it was felt that the reasons for the practices probably shed light on people's perceptions of sexuality. From a review of historical and medical texts, several kinds of penile operation were documented as a substantial practice among men in Southeast Asian countries especially among Thai men. Circumcision is another kind of operation that a large number of men believed was done to sexually please their female partners. Several kinds of penile operations perhaps reflect the fun-loving nature of Thai men which has been observed before by some anthropologists. The term *sanuk* or enjoyable which means 'fun-loving', 'pleasure loving', 'deep interest in something, momentarily, to the exclusion of all else' is used to describe the dominant nature of Thais

(Embree, 1950; Kinghill, 1960). Although most writers have suggested that men adopted these penile operations to sexually please their female partners, this study argued that some men probably adopted the operation to make up for the fact that women were likely to suppress their feelings of sexual arousal. It is suspected that some women may object to coitus with husbands since they perceived sex as polluting and dirty. A significant number of women compared to men reported that they were offended with the seminal fluid after coitus. About 20 per cent of currently married women reported that they always inserted fingers to clean out the seminal fluid every time after coitus, a method used by most prostitutes.

A large number of men believed that STD infection was preventable or was easy to cure so the infection had never been perceived as a threat to them. The prevalence of self-reported STD infection among men has been high: about half of men aged 15 to 49 were once infected with STD. However, most men claimed that they were infected with STD only before marriage. Between four and five per cent of currently married men and women reported having had STD after marriage. As a large number of men pay for sex with prostitutes while single, several methods have been used to prevent STD infections. Some men perceived that *coitus interruptus* could prevent them from getting an STD, which shows their lack of understanding about the route of the infection and their lack of basic knowledge of anatomy and physiology. The lack of knowledge has led to similar myths and beliefs about AIDS as shown in Chapter 8.

CHAPTER 8
Responses to the Outbreak of AIDS

The AIDS epidemic emerged in Thailand more than ten years ago, but the government started to make efforts to promote education and a prevention campaign only in the late 1980s (see Chapter 2 for details). A large number of people with AIDS and HIV in the early years, who were mainly prostitutes from the Upper-North region, were sent back to their home provinces from 1989 until around 1991 in an attempt to control the spread of HIV. However, this policy was profitless; many prostitutes with HIV resumed working as prostitutes again when they returned to their provinces. The habit of men in having casual sex contact with prostitutes without condom use has led to an extremely high prevalence of people with AIDS and HIV in the Upper-North provinces since the early 1990s. People in the rural areas were well aware of the AIDS outbreak during the time of the fieldwork. This chapter describes how people respond to a perceived threat of AIDS and how there is a need to adapt behaviour accordingly. The sexual contact in recent years is explored.

8.1 GENERAL RESPONSES

People in the rural areas became aware of the existence of AIDS only in the past few years when they had themselves seen people with AIDS symptoms.[1] When the government launched the educational campaign in the late 1980s, very few people recognised that AIDS would become an important infectious epidemic.[2] People in the village did not pay much attention to the government's campaign about AIDS at that time: they perceived themselves to be at no risk of getting it. Some people recalled confusion when the government launched the condom use campaign telling men to always use condoms with prostitutes: they believed the government was pressed by some Western countries to promote condom sales. Others said the government probably made up the stories about AIDS to stop men from visiting prostitutes. The extensive HIV case-finding begun in 1989 led to further confusion because people could not distinguish between those with HIV and those with AIDS; people with HIV did not perceive themselves to be infected because they felt normal with no symptoms of illness. In the early years of the AIDS outbreak, many men did not abstain from casual sex contact with prostitutes; their awareness about AIDS at that time did not evoke their concern that AIDS would be spread through unprotected sex with prostitutes.

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1 In all but one village selected for this study, between one and four persons had AIDS or had died of AIDS. Four male respondents had AIDS symptoms: one of them could not complete the interview because of his illness. Life histories of people with AIDS are given in Appendix C.

2 Photographs of people with AIDS were often used in the poster displays to emphasise the existence of AIDS. This campaign was successful in raising the people's awareness about AIDS but it failed to protect the image of people with AIDS who were subsequently rejected from the society for fear of infection (Borthwick, 1995, personal communication; see Hongwiwat et al., 1993a, 1993b).

Moderator: When did AIDS start to spread ?
1st wom: People say it comes in 1984, but we have started to see people with AIDS in 1992-1993, they have started to die only in recent years.

Urban village, married women

Moderator: When did AIDS start to spread in this community?
1st wom: Only last year [in 1993].
2nd wom: People have started to die from AIDS last year, and many die within this year.

Rural village, married women

Headman: When did people in our village start to believe that AIDS is real?
1st man: They have started to be afraid of AIDS last year [1993].
2nd man: In 1992.
1st&3rd man: Many men had not stopped *aeo sao* in 1992.
1st man: People are most afraid of contracting AIDS in 1993. Most men stop going to brothels this year from fear of getting AIDS, but some still did in 1992.
2nd man: I stop this year, but I did last year [1993].
Headman: Maybe we can say that people start to believe about the existence of AIDS between 1992 and 1993.

Rural village, married men

Headman: When did AIDS become well-known in our village?
1st man: In 1993.
2nd man: No, since 1990.
1st man: But it is most known in 1993.
Everyone: People start to die from AIDS in 1992.

Urban village, married men

In agreement with reports from other studies (Hongwiwat et al., 1993a,b: Chaipibansiri, 1993), the unpleasant appearance of people with AIDS had led to rejection and stigmatisation of people with AIDS and their families. People in the village would not take food or drinks prepared for the funerals of those who had died of AIDS from fear that the disease might be transmitted this way. They refused to eat food prepared by people with AIDS and their relatives. All barber shops were forced to use a new razor blade with every customer or else no one would come to the shops. A number of men with HIV infection entered the monkhood to escape the rejection from society, but this raised the concern that an increasing number of monks with HIV infection would damage the image of the religion: Buddhist monks vow to abstain from sexual engagement; therefore, they are not supposed to be infected with HIV. Some abbots consequently requested men with HIV not to enter the monkhood to maintain the respect of the people. Although people were frightened and started to believe that AIDS was real, men 's sexual behaviour had only slightly changed in the early years. Not many men would regularly use condoms with prostitutes; some thought that AIDS was a kind of STD which could be treated; others adopted methods to protect themselves from getting the infection, for example they would select particular types of prostitutes or places that they thought were less likely to have AIDS. Some men paid more not to use a condom despite their awareness of AIDS.

From discussions with prostitutes and observation at their workplaces, it appears that changes in men's behaviour have been happening only in the past two years when an increasing number of people were found to have AIDS. Some brothels were forced to close down or were changed to other types of sex business like restaurant bars or karaoke clubs: some men perceived services in these places to be safer than those given in the brothels. The condom use rate has increased sharply in recent years because most prostitutes require the use and free condoms are available at the sex outlets. Although a number of such places were forced to close, various types of sex business were still obvious in the Chiang Mai city. Interviews with operators of brothels, karaoke clubs and massage parlours between 1993 and 1995 revealed that nearly half of about 20 brothels in a well-known red-light district of Chiang Mai had closed recently because of lack of customers. Nevertheless, observation in two brothels in late 1993 and early 1994 showed that although one brothel lacked customers, the other one nearby, which charged a low price of only 50 baht ($2.5) for half an hour, was busy with customers. The operators at karaoke clubs, bars and massage parlours said that their business had been little affected by the spread of AIDS in Chiang Mai. This was in accord with observations in mid-1995 that the number of men visiting these places was still substantial. The regular use of condoms probably causes the prostitutes and their clients to believe that they are at low risk of getting AIDS. Some men perceived that paying for sex with condom use was safer than sex with non-prostitute partners: they said that the prostitutes had a regular medical checkup and the doctor certified that they were free of disease. Apart from that, unlike the case with prostitutes, condom use with non-prostitute partners was difficult because it might indicate a lack of trust in the partners.

Headman: What is safer between having sex with prostitutes and with non-prostitute women?
Several men: Prostitutes.
1st man: Because prostitutes have a certificate saying that they are free of diseases.
Headman: You mean the doctor has certified that these women are safe?.....Do all of them have the certificate?
1st man: I am not quite sure. They always show me that they have the certificate.
Headman: Some men your age around 18 to 25 often ask for the certificate to make sure that the prostitutes are free of diseases.

Rural village, single men

All brothel-based prostitutes are required to have a weekly medical checkup at the government STD clinics; some indirect prostitutes like masseuses may receive a regular medical checkup at private clinics. Those who have had the checkups would be certified in a small booklet that they have seen a doctor for a regular checkup. However, this medical checkup was just a routine vaginal examination to detect local infection only. Some massage parlours may require their prostitutes to have an STD or HIV blood test every three months; however, the brothel-based prostitutes do not usually receive the blood tests during the routine checkups unless they have experienced STD symptoms, or if they are chosen for the HIV blood test for the National Surveillance. Therefore, this

routine medical checkup does not certify, as they believe it does, that the prostitutes are free of disease.

No woman in the survey villages was found to have AIDS during the fieldwork. This may be because very few women in the areas had worked as prostitutes, and most people with AIDS were single men with no regular partners except prostitutes. In the rural village where I stayed for participant observation, it was said that more than 20 women from this village had worked as prostitutes. However, most of them worked as prostitutes before the emergence of AIDS so it was unlikely that they would be HIV infected from being prostitutes. Women with HIV were more likely to get the infection from their husbands, except in a few villages where many women worked as prostitutes and later became infected with HIV themselves. It seemed from discussion with a former brothel owner that prostitutes with AIDS tended to live at the brothels until they died; some might return home after knowing that they were infected. Some would continue working despite their knowledge that they were HIV infected. Some might change their workplace or marry. In discussions with prostitutes, they claimed to have seen some friends dying from tuberculosis or pneumonia, not AIDS. Those found to be infected did not tell others that they were infected from fear of losing their jobs and of discrimination.

8.2 BELIEFS ABOUT MODE OF HIV TRANSMISSION

The fact that few women in the village had AIDS led to a strong belief among rural people that women were at low risk of getting AIDS mainly because they could drain the infected blood through menstruation every month. Discussions with married men and women showed their belief that women were not prone to get HIV, or women with HIV would not develop AIDS symptoms as quickly as men do. Unlike women with natural blood draining, HIV-infected men could not cure themselves by draining the infected blood.

Headman: Do women have a chance to get AIDS?
1st man: Of course, but men are disadvantaged because they could not exchange blood.
Headman: How do women get AIDS?
2nd man: They are infected from their husbands.
Headman: Who is at higher risk of getting AIDS between men and women?
3rd man: Men because they could not exchange blood and also they often have sex with prostitutes.

Urban village, married men

Moderator: Some say women are less likely to get AIDS. How do you believe about this?
1st wom: It is true because women could rid of infected blood.
2nd&3rd wom: They will be infected but very slowly because their bad blood would be drained through menstruation.
2nd wom: A few days ago, a menopausal woman aged 50 in the nearby village died of AIDS.
Several: Is she the one who often wandered around flirting with many men?
2nd wom: She is promiscuous. Before she died from AIDS, she often changed partners every four to five days. What a pity for men who had been engaged with her.

Rural village, married women

Headman: I heard people often say that women are able to exchange blood, is it true?
1st man: The menstruation clears bad blood out of the circulation. Women will die from AIDS like men do, but slower than men because women do not drink as much as we do. Men also work harder than women so we are prone to infection.
2nd man: The only difference between men and women is that women could drain poor blood every month. Men could not do it so the bad blood accumulates inside their bodies. They fall ill quicker than women.
1st man: In that case, men should be smashed to drain out the bad blood....(laughs)
3rd man: It does not work that way. It is a different kind of blood draining.

Urban village, married men

School students aged over 15 years who live in the villages had good knowledge about AIDS because all were informed several times at school. However, some of their beliefs about the mode of HIV transmission showed little difference from those of other people in the villages.

Moderator: How can HIV be transmitted?
1st student: Infected from husbands.
2nd student: From shared razor blades.
3rd student: Sharing toothbrushes among those who brush until bleeding.
1st student: From having papaya salad. When the infected person slices the papaya and cut herself, the blood would be mixed into the salad and whoever eats it has a chance of getting AIDS [Agreed by everyone saying that none had bought papaya salad recently because they were afraid of contracting AIDS].
4th student: The toilet has to be super clean. To be sure, flush three times and cover the seat with three layers of paper tissue before you can sit on.

Rural village, female students

Headman: How can AIDS be transmitted?
1st man: It can be equally transmitted from having sex with prostitutes or taking drug injection.
Headman: Are you afraid of receiving injections at the hospital, or using shared toilets? Will they lead to infection?
1st man: Of course, the disease is in the urinary organ. If you do not urinate after intercourse, the disease remains inside the body. Urination drains out the disease. I often urinate right after intercourse with prostitutes and I have never got any STD infection.

Rural village, married men

Regarding HIV transmission through sexual contact, many male informants claimed that *coitus interruptus* could prevent HIV transmission just the way it prevents STD (see Chapter 7). They seemed to lack the basic knowledge that HIV is transmitted by the exchange of bodily fluids between infected and non-infected persons. They perceived that the transmission of HIV would be similar to the transmission of other STDs such as gonorrhoea or syphilis. They believed that *coitus interruptus* would discard the HIV out of their genital tract after coitus with at-risk people, and they would be less likely to be infected. To quantify this belief, all respondents were asked whether they believed that *coitus interruptus* would prevent them from contracting HIV. The results are given in Table 8.1.

Table 8.1 Per cent distribution of sexually experienced respondents according to their belief that *coitus interruptus* could prevent HIV infection

	Agree	Disagree	Undecided	TOTAL %	TOTAL N
All men and women aged 15 to 49	18	52	30	100	605 [a]
Single men without sexual experience	39	46	15	100	26
Single men with sexual experience	27	58	15	100	59
All men who ever paid for sex	17	71	12	100	218
Women with sexual experience	17	38	43	100	271[b]
Currently married men	16	72	12	100	194

a Twelve men and women did not understand about *coitus interruptus* after explanation, missing cases=2.
b Two women did not understand about *coitus interruptus* after explanation.

People in the villages were well aware that HIV can be transmitted by heterosexual intercourse and needle sharing. However, particular beliefs about needle sharing were noted. Despite the evidence of drug dealing in the villages as mentioned in Chapter 3, injecting illicit drugs was not cited as a significant mode of HIV transmission. People were rather concerned that HIV might be transmitted by needle sharing from injections received at hospitals or health stations, especially among women who received frequent injections for contraception. They claimed that in the past few years the health staff gave them contraceptive injections using the same syringe and needle. The one needle per injection policy was introduced only recently when the outbreak of AIDS became well known. They were not sure whether those receiving the injections with shared needles in the past years were at risk of HIV infection. [3]

1st wom: A new needle is used with each contraceptive injection now. It costs twenty baht [A$1] for the cost of needle change.
2nd wom: Only the needle is changed, the same syringe from the previous injection is still used with subsequent patients though.
3rd wom: I have heard that the needle change just started not long ago.
2nd wom: Remember when we went for contraceptive injections together in the past, the same needle was used with many people.
Moderator: When was that?
4th wom: About four to five years ago [around 1988-1989].

Urban village, married women

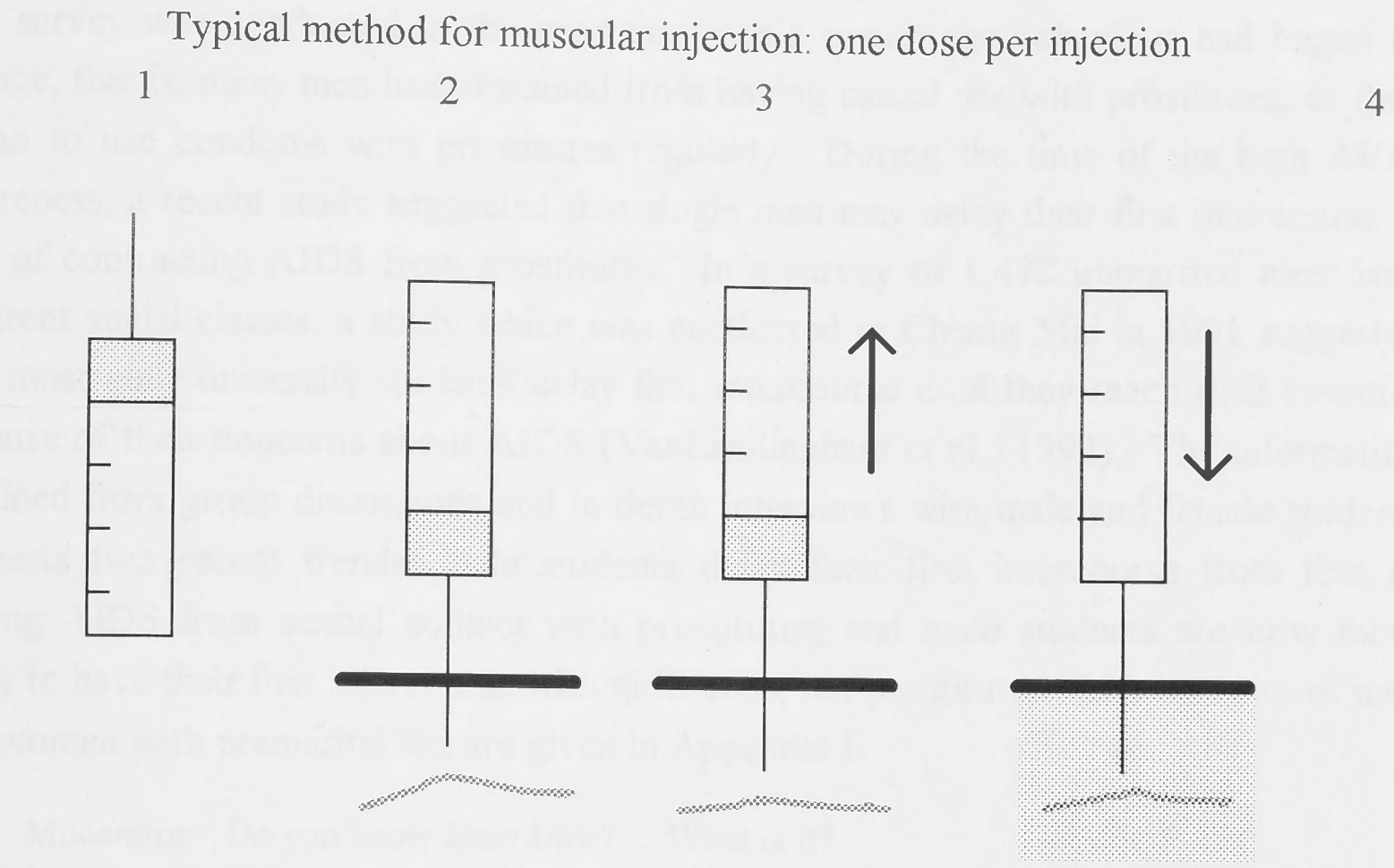
3 The cross infection of HIV from patient to patient through medical procedures has been occasionally reported in Western countries: however, the incidence of people with HIV who received the virus from medical procedures has not been publicly reported in Thailand.

Moderator: How is HIV transmitted?
1st wom: From sharing needles.
2nd wom: I heard the radio says from sexual intercourse and blood transfusion.
3rd wom: Definitely from sexual intercourse.
2nd wom: I heard that a woman from the other village died from AIDS. She was infected from needle sharing for contraceptive drug injection. In the past, one needle would be used with five women.
1st wom: It is no longer like that, this has changed now.

Rural village, married women

The evidence of syringes being re-used for several injections with different people was detected from an interview with a nurse at the village health station in October 1993. She said that a new needle had been used for each injection in the past few years since AIDS had become an outbreak. However, she admitted that with a limited number of syringes she would draw a multiple dose of a drug into one syringe to be used with several patients as shown in Figure 8.1. After the first person was infected, a subsequent patient would receive an injection with a new needle attached to the same syringe used previously. She perceived that the risk of contracting HIV by this kind of injection would be small as the drug was pushed into the muscle without a blood drawing test. This kind of injection was performed when many people turned up for injections at the same time and the supplies were not available to serve a large number of patients, for example vaccinating school children or giving contraceptive injections to many women. Several women from villages 9 and 12 claimed that the health staff from their villages still provided them with this kind of injection.

Figure 8.1 Multiple injections using the same syringe-new needle method



(1). Prepare drug, one dose per patient, (2) Inject muscle, (3) Draw up syringe to check location of the needle. If tip of the needle is located in the blood vessel as in picture 8, the blood tint will show up when drawing up the syringe. Re-position of needle is needed or else the injecting drug will go directly into the blood stream which may affect the onset of drug interaction, (4) Inject drug if no blood appears, (5) Drug preparation for multiple dosage to be used with several patients using the same syringe, (6) Inject one dose of drug without blood drawing test, (7) Attach a new needle to same syringe and inject another dose in next patient, (8) Repeat injection with subsequent patient.

8.3 RECENT CHANGES IN CASUAL SEX CONTACT BY MEN

8.3.1 First Intercourse in the AIDS Era

The survey was conducted in the year that men's casual sex behaviour had begun to change, that is, many men had abstained from having casual sex with prostitutes, or they began to use condoms with prostitutes regularly. During the time of the high AIDS awareness, a recent study suggested that single men may delay their first intercourse in fear of contracting AIDS from prostitutes. In a survey of 1,472 unmarried men from different social classes, a study which was conducted in Chiang Mai in 1991 suggested that most male university students delay first intercourse until they reach their twenties because of their concerns about AIDS (VanLandingham et al., 1992). The information obtained from group discussions and in-depth interviews with male and female students suggests two recent trends: male students delay their first intercourse from fear of getting AIDS from sexual contact with prostitutes, and male students are now more likely to have their first intercourse with girlfriends, not prostitutes. Life histories of men and women with premarital sex are given in Appendix E.

Moderator: Do you know *khun khru*?.....What is it?
1st man: Taken to a brothel by *run phii* (older age male friends)
Moderator: Is it still practised now?
2nd man: No. It is not safe. You may get AIDS
Moderator: For school students like you, at what age does first intercourse occur?
3rd man: By age 18, may be.
Moderator: All of you will be 18 very soon. Who will be your first sexual partner, do you think?
Everyone: A girlfriend

Urban village, male students

Moderator: Do you think your male friends still practise *khun khru* or not?
1st wom: Not sure. Maybe very few now. Since AIDS comes many teenage men tend to have sex with girlfriends, not prostitutes.
2nd wom: They are afraid of getting AIDS now so they tend to have sex with married women instead. It's safer (from getting AIDS) this way.
3rd wom: Well, I had heard my male friends still talk about *khun khru*. They might still practise it. It's hard to tell. Once they have an urge, they have to do it. They don't care about AIDS.

Urban village, female students

8.3.2 Recent Casual Sex Contact with Prostitutes

To assess recent casual sex contact, all sexually experienced men were asked whether they had sexual contact with prostitutes in the past twelve months. The length of time that men last paid for sex with prostitutes is given in Table 8.2.

Table 8.2 Percentage distribution according to length of time since respondents last paid for sex by age group and marital status

	Did not stop last year	Had stopped in past years				TOTAL
		1-3	4-5	6-10	> 10	
All single men [a]						
15-29	25	7	0	6	0	38
30-39	7	6	6	1	1	21
40-49	0	0	1	1	0	2
Total per cent	32	13	7	8	1	61[a]
Number of respondents	27	11	6	7	1	52
All currently married men [b]						
15-29	1	3	4	4	1	13
30-39	4	7	8	12	8	39
40-49	1	4	4	6	13	28
Total per cent	6	14	16	22	22	80[b]
Number of respondents	12	28	31	42	42	155
All men aged 15 to 49 [c]						
15-29	8	4	3	4	1	20
30-39	6	7	7	9	6	35
40-49	1	3	3	4	9	20
Total per cent	15	14	13	17	16	75[c]
Number of respondents	41	42	39	49	47	218
All single and married men who ever paid for sex						
15-29	10	6	4	6	1	27
30-39	9	9	10	10	8	46
40-49	1	4	4	6	12	27
Total per cent	20	19	18	22	21	100
Number of respondents	41	42	39	49	47	218
Single men who ever paid for sex in a lifetime						
15-29	40	12	0	9	0	61
30-39	12	9	10	2	2	35
40-49	0	0	2	2	0	4
Total per cent	52	21	12	13	2	100
Number of respondents	27	11	6	7	1	52
Currently married men who ever paid for sex in a lifetime						
15-29	1	5	5	5	1	17
30-39	5	8	10	15	10	48
40-49	2	5	5	7	16	35
Total per cent	8	18	20	27	27	100
Number of respondents	12	28	31	42	42	155

(continued)

(Table 8.2)

	Did not stop last year	Had stopped in past years 1-3	4-5	6-10	> 10	TOTAL
Currently married men who ever paid for sex after marriage						
15-29	1	5	4	0	0	10
30-39	11	14	11	16	3	55
40-49	4	9	8	9	5	35
Total per cent	16	28	23	25	8	100
Number of respondents	12	21	17	19	6	75
Married men in their first marriage who ever paid for sex after marriage						
15-29	2	5	5	0	0	12
30-39	12	11	11	18	3	55
40-49	3	8	8	9	5	33
Total per cent	17	24	24	27	8	100
Number of respondents	11	16	16	18	5	66

[a] The total percentage is not summed to 100 per cent because the total of 85 single men was used as the denominator.
[b] The total percentage is not summed to 100 per cent because the total of 194 currently married men was used as the denominator.
[c] The total percentage is not summed to 100 per cent because the total of 293 single men was used as the denominator.
The denominator includes single men without sexual experience (n=26), single men who never paid for sex with prostitutes (n=7), and married men who never paid for sex with prostitutes (n=42).

About 75 per cent of men aged 15 to 49 had ever paid for sex in a lifetime and 15 per cent did pay for sex in the past 12 months. Only six per cent of currently married men reported paying for sex in the past year. Single men aged between 15 and 29 are most likely to have recent casual sex contact with prostitutes: about 40 per cent of them reported paying for sex with prostitutes in the past 12 months. Two out of 11 men who were divorced, separated or widowed said they paid for sex in the last twelve months.

The frequency of casual sex contact with prostitutes in the past year was low. The median number of times that men paid for sex in the last twelve months was three times: of single men, about 76 per cent said they paid for sex not more than three times while 24 per cent did so more than 10 times in the last year; of currently married men, about 30 per cent paid for sex from four to six times in the last year while the rest did so less often.

Although a face-to-face interview may restrain the respondents from telling the truth about their recent sexual contact with prostitutes, information obtained from group discussions similarly suggested that a decreasing number of men, especially married men, had paid for sex in recent years.

Headman: There are many people with AIDS now. Do men still *aeo sao*?
Several: From what we have seen, not many men go now. They've stopped. Very few like those who often get drunk may go, but the number is few.
Headman: Without AIDS, men *aeo sao* a lot in the past.
1st man: Men still frequent *aeo sao* when AIDS was known in the early years.

2nd man: They went every 5-6 days.
Headman: Is it possible that men would abstain from *aeo sao* permanently?
All: Not possible, they probably start going again when the treatment is available. With exceptions though, they may stop once they have a family.
Headman: They stop not because they are getting old but they just abstain for a while because of AIDS. It doesn't mean that they will stop forever.
3rd man: Of course not....It is men's happiness....[laughs]
4th man: Because of being drunk also.
Headman: There are many people with AIDS now, are you afraid?
1st man: Of course, very afraid....or else why abstain from *aeo sao*.

Urban village, married men

Table 8.3 shows the attitude of men about their casual sex contact with women in the AIDS era: most men except those who paid for sex in the past year claimed that they would be able to abstain from casual sex contact with prostitutes and non-prostitute women for all time. In addition, only between 60 and 80 per cent of men and women claimed they would prohibit their son, if they have any, from prostitute patronage.

Table 8.3 Per cent distribution according to attitudes about recent sexual contact of men

	Agree	Disagree	Undecided	TOTAL %	TOTAL N
Because of AIDS outbreak, I can abstain from having sex with prostitutes at all times.					
All men aged 15 to 49	89	5	6	100	293
All single men	75	11	14	100	85
All currently married men	94	3	3	100	194
All men who ever had sex with prostitutes	88	6	6	100	218
All men who had sex with prostitutes in the last 12 months	56	23	21	100	43
Currently married men who ever paid for sex after marriage	90	5	5	100	75

(continued)

(Table 8.3 continued)

	Agree	Disagree	Undecided	TOTAL %	TOTAL N
I can abstain from having sex with casual partners who are not prostitutes at all times.					
All men aged 15-49	89	5	6	100	293
All single men	73	9	18	100	85
All currently married men	94	3	3	100	194
All men who ever had sex with prostitutes	86	6	8	100	218
All men who had sex with prostitutes in the last 12 months	51	23	26	100	43
Currently married men who ever paid for sex after marriage	89	7	4	100	75
I would prevent my son, if I have any, from prostitute patronage.					
Single women	67	17	16	100	58
Currently married women	76	7	17	100	251
Currently married women with at least one son	77	7	15	100	149
Single men	68	26	6	100	85
Currently married men	66	31	3	100	194
Currently married men with at least one son	68	29	3	100	117
Men who ever paid for sex with prostitutes	61	34	5	100	218
Men who never paid for sex with prostitutes	82	16	0	100	49

The time when AIDS became an epidemic gained much attention through group discussions because men were concerned whether they were at risk of contracting HIV. Some assumed that they would be AIDS-free if they had abstained from having sex with prostitutes before the year that AIDS became an outbreak. Note that the period in which an infected person was believed to develop AIDS was four years, but the period was shortened among Thais with HIV because a large number of those found to be infected usually presented themselves for the blood test only after they had experienced AIDS symptoms.

Headman: When did AIDS first emerge?
1st man: In 1993 [the year of data collection].

2nd man: No, since 1990.
1st man: But it becomes most well-known in 1993.
Everyone: That's right. People with AIDS started to die in 1992.
Headman: But they must be infected long before that time.
3rd man: Who knows for sure when the infection has started to spread?
Headman: Well, how many years can the infected person live then?
3rd man: Four years, but maybe longer with good resistance.
Headman: Started to die in 1992.....so the infection must be spreading since 1988 then.

Urban village, married men

8.3.3 Last Sexual Contact of Men

Brothels were a typical kind of sex outlet where men went for casual sex with prostitutes: most men said their last sexual contact with a prostitute was at a brothel; only about 13 per cent of them, most of whom were married men, claimed their last casual sex contacts were with indirect prostitutes such as call-girls, masseuses, or waitresses. About 65 per cent reported the cost of their last sexual contact with a prostitute was less than 100 baht (A$5).

According to questions asked about last intercourse, all except one currently married men reported the wife as their partner at the last intercourse; one currently married men said that his last sexual intercourse was with a casual girlfriend who was not a prostitute; 73 per cent of them had the last coitus in the last week. Among single men with sexual experience, about 63 per cent of them said their last intercourse was with a brothel-based prostitute, 15 per cent said it was with a casual girlfriend, 17 per cent said it was with a girlfriend and for the rest it was with another non-prostitute partner; about 78 per cent of them had the last coitus more than two months ago.

8.4 REASONS FOR PROSTITUTE PATRONAGE IN THE AIDS ERA

An increasing number of men were likely to abstain from prostitute patronage from fear of getting AIDS; however, a small number of them claimed that they would continue to have sex with prostitutes. In response to the question whether or not they had abstained from casual sex with prostitutes, 22 out of 293 men or about eight per cent of men aged 15 to 49 reported that they had not yet given up sex with prostitutes. About 16 per cent of all single men or 24 per cent of those with sexual experience reported they would not stop paying for sex with prostitutes which is in accordance with their attitudes presented in Table 8.3. Only three per cent of all currently married men or eight per cent of these who ever paid for sex after marriage reported they would continue to pay for sex with prostitutes.

From qualitative data, there were various reasons for men to have or not to have sex with prostitutes in the AIDS era. The following reasons cannot be quantified in numbers but they were listed in order starting from the reason that was cited most.

SINGLE MEN

Reasons to pay for sex

Friends' persuasion
Influence of social drinking
Not afraid of getting infection e.g. condom use or *coitus interruptus* would prevent infection, pay more for safer partners (indirect prostitutes)
Feel lonely because of no girlfriend or being away from home
Self-reward
Have sexual desire but do not have any stable partners
Want to learn about sex

Reasons to abstain from paying for sex

Postpone the first sexual experience from fear of getting AIDS
Sexual abstinence from fear of getting AIDS
Masturbation
Have other sexual partners
Sexual abstinence because lacks money, too shy, no desire, afraid of parents' knowledge
Dislike sexual contact with prostitutes

CURRENTLY MARRIED MEN

Reasons to pay for sex

Friends' persuasion
Influence of social drinking
Not afraid of getting infection, e.g. condom use or *coitus interruptus* prevents infection, pay more for safer partners (indirect prostitutes)
Sexual abstinence with wife from being away from home for work
Self-reward
Sexual abstinence with wives at certain periods e.g. during pregnancy
Wife refuses to have sex e.g. because of old age, illness, no mood, weary from daily work
Get bored with wives or having family conflicts
Want to experience sexual practices that wife would not do

Reasons to abstain from paying for sex

Have family
Not interested in casual sex with other women e.g. too busy with family, weary from daily work, old age
Do not want to pass the infection to wife and children
Have other casual partners e.g. second wife or non-paid partner
Friends stop going for commercial sex

8.5 PERCEIVED RISK OF INFECTION AND HIV BLOOD TEST

All respondents were asked whether or not they perceived themselves to be at risk of getting AIDS. As shown in Table 8.4, about one-third of men and one-fifth of women felt they were at risk and about half of male respondents would like to have the HIV blood test. The reasons for the perceived risk of getting AIDS are shown in Table 8.5. Among those who believed they were not at risk, a majority claimed they never had sexual contact, never paid for sex, or had abstained from having sex with prostitutes before the emergence of AIDS. Some further claimed that they were healthy with no

weight loss so they were quite confident that they would be AIDS-free. Among those who perceived themselves to be at risk, the majority said AIDS might be contracted by taking food or drink prepared by infected persons, receiving medical injections or blood transfusions with shared needles, or being in accidental contact with infected blood. Many men believed they might contract AIDS by having a shave at the barber shop where the same razor blades are used for many men. Their reasons include the following examples:

> Not sure whether or not I have a risk of getting AIDS because a man living next door has AIDS (married man, ID 58).
>
> I may be at some risk because I have often received injections at the hospital, but new needle is being used now (married man, ID 148).
>
> At medium risk because of two reasons: first, I have haemorrhoids so it is likely that I would get AIDS when using public toilets. Secondly, I may be infected from sharing razor blades at the barber shop (married man, ID 345).
>
> No risk because I have gained weight gradually with no sign of illness (married man, ID 411).
>
> At medium risk because I am a cook. I may cut myself and contact the blood from infected pigs (married man, ID 431).
>
> At low risk. I may contact infected blood when going to help people in car accidents (married man, ID 619).

Percentage distributions according to men's reasons for having an HIV blood test are shown in Table 8.6 and those for their spouses having the test are shown in Table 8.7. From Table 8.6, more than 10 per cent of currently married respondents claimed that an HIV blood test was not necessary as they had had the test already. However, confusion about the blood test was detected as listed in the following points.

Lack of Knowledge about Blood Test

People in the villages seemed to lack common knowledge regarding blood testing in general, not only about HIV blood testing. Once their blood is taken for a test, some people seemed to believe that all kind of defects within the blood will be detected at once. Some claimed they had a normal blood test; however, with a detailed conversation reviewing their symptoms it was found that what they previous claimed to be HIV blood tests were just blood sugar tests or anaemia tests. Five other interviewers lacked health knowledge so they were unable to detect people's confusion in this matter. The following examples show how people were confused about blood tests.

HIV blood test is not needed because:

> I have got a blood test already when my child was treated for anaemia (married man, ID 549).
>
> I once had the blood test and the result was one plus (married woman, ID 87).
>
> I have AIDS test every three months when going for contraceptive injections at the village health station (married woman, ID 305).

I have a comprehensive physical examination every year, and it has confirmed that I am not ill or infected with any diseases (married woman, ID 102). [4]

I received a blood test ten years ago when pregnant (married woman, ID 197).

HIV blood test is compulsory at school (grade 11 single male student aged, ID 394). [5]

I was admitted to the hospital once and the doctor had already taken blood test several times (married man, ID 473)

HIV blood test is needed because:

I often have headache, muscle-ache and bone-ache. The purpose of having the test is for health reasons not merely for HIV detection (married man, ID 409 and 602).

The group discussion below showed the confusion of people about the HIV blood test.

Headman: How can you tell that a person has AIDS or not?
1st man: When people with AIDS go for a blood test, do you know that the doctors do not tell them the truth? [6]
2nd man: It depends on your spiritual strength. Like in Chai's case [who was infected and died with AIDS]- the doctor only told him that his blood was positive, not that he got AIDS. Then someone talked to his face that he had AIDS and this made him fall sick quickly only within two months later. He died because of weak spirit, not AIDS. Faint hearted.

Urban village, Married men

When I was first found to be HIV infected, the doctor did not tell me directly that I got AIDS. He said I had got a *hit* or 'popular' disease. He thought I would understand that he meant AIDS, but I did not get it at first, I thought he told me that I was ill with a disease called *hit*.

Single man with AIDS, 24

Beliefs about Alternative Blood Test for HIV

Some people perceived the blood test given to women during pregnancy as an alternative way of having an HIV blood test. Many married women believed that they were not infected with HIV because they had had the test during the last pregnancy. In the early years of the AIDS outbreak, almost all pregnant women coming for antenatal care at the government hospitals were tested for HIV without their consent and were informed of

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4 A comprehensive physical examination is popular among Thais who believe that the service will ensure that they are disease-free. Without any specific symptoms, these people would turn up regularly to see the doctor and request a physical examination. Usually, a blood test would not be performed without any suggested symptoms. Some patients would also demand a medical injection or fluid transfusion to regain their strength as they believed.

5 It is very unlikely that any schools would require their students to have HIV blood tests. However, the blood test for hepatitis B may be conducted extensively in many places including educational institutes to promote injection of hepatitis B vaccine. This student may be confused between HIV and hepatitis B blood tests.

6 For instance, one woman suspected that her husband probably had AIDS as he frequented prostitutes very often. Both of them went for HIV blood tests and they were informed that her husband had hepatitis B. They were asked to use condoms every time during sexual intercourse. However, her husband was increasingly upset when she insisted on this every time. He claimed he has not got AIDS so she should not be afraid of him. Both of them were frustrated not knowing when they could stop the use.

the result.[7] However, the Ministry of Public Health launched a new policy in 1992 aiming to restrict the HIV blood test to those who are at risk only and to provide those coming for the test with counselling (see detail in Chapter 2). Therefore, it is believed that the HIV blood test would be limited: only those who are at risk of getting HIV would be tested. Nevertheless, the general public may not aware of this changing policy: a number of them may continue to believe that the blood test during pregnancy would include an HIV test, which is not always the case.[8] For the purpose of the National HIV Surveillance, only about 100 pregnant women attending the ANC clinics at the government hospitals in each province would be selected for HIV blood test twice a year.

Blood donation is another alternative to having an HIV blood test. Some men would not go for the HIV blood test given at the government services because other people might say that they are HIV infected, even though they merely turn up for the test: therefore, they would rather go for blood donation with an intention to have an HIV blood test. They assumed that they would be free of having HIV if their blood was taken without any questions or warning. Their belief about HIV tests among blood donors was partly true as all units of donated blood have been tested for HIV since 1989 (see Chapter 2). Similarly to the case of pregnant women, the blood donors with HIV were informed of their positive blood test in the early years of the AIDS outbreak, but the situation has changed; blood donors with HIV have not been informed about their blood test result since 1992; the donated blood with HIV is discarded.

Risk of HIV Transmission from Sharing Medical Instruments

Some people would like to have the HIV blood test but they did not want to go for the test because they were afraid that HIV might be transmitted from the needle used for the blood test. Only new needles were used for each patient: however, sharing syringes for medical injections was detected. It is unknown how many people in Thailand may have been infected with HIV from cross-infection by medical instruments.

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7 The policy of having HIV blood tests among pregnant women varies from place to place. Although the HIV blood test is recommended for at-risk persons with informed consent only, some hospitals may require all pregnant women to have anonymous HIV blood tests for the purpose of cross-infection prevention. It is unknown whether or not the pregnant women would be informed if they are HIV-infected. However, the inconsistent policy of HIV blood tests among pregnant women has led to confusion: they tend to believe that they are tested for HIV when pregnant; unless informed, they perceive themselves to be AIDS-free. Despite the policy of restricting the HIV blood test to at-risk people, the HIV blood test has been widely performed among low-risk people e.g. most jobs, especially in government work, require recruits to be free of HIV infection.

8 The routine blood test for pregnant women in Thailand usually aims to rule out anaemia and venereal diseases. Blood sugar and other conditions may be tested on a case-by-case basis. Unlike the situation in the Western countries, a high ratio of patients per health staff at the government hospitals has easily led to a lack of communication between patients and health staff. A large number of patients may not be informed about their treatments in detail. They may not know why the blood is taken for the test. As a result, some people assumed that all defects can be detected by a single blood test.

Confusion about Timing to Have HIV Blood Test

People expressed their concern about the time when one should go for the HIV blood test. Some men went for the test after at-risk behaviour, for example, a few days after having sex with prostitutes, and some regularly had the test a few times as they lacked knowledge about the window period when HIV cannot be detected in the bloodstream as shown in the group discussion below.

Headman: Would you like to have the blood test, or you are afraid of the result?
Everyone: We are too afraid to know the result.
1st man: I don't think I have AIDS because my wife just had a blood test when she was pregnant.
2nd man: But you need to have the test every 3 to 6 months.
1st man: Just observe from the baby then.
2nd Man: How can you just look at the baby? We might be infected with AIDS later because there is a six month latent period.
Headman: From my knowledge, the duration that the disease [HIV] becomes symptomatic is ranging from two to six years.[9] The last time I went to brothels was in 1986. AIDS became an outbreak between 1991 and 1992, but this is now the seventh year after my last visit so I believe that I am pretty much safe from AIDS, it has passed the infection period now. If you just abstained from *aeo sao* recently e.g. last month, are you confident that you are free from AIDS if the blood test is negative? The infection period is very long, up to six years as I said. If one went *aeo sao* three months before having a test, the result may be good, and the doctor may save your blood for later use in the following year. Who knows that the negative blood may turn positive over a year when the doctor later uses it with other people. You cannot be so certain about the HIV blood test. It is very tricky, you know.
1st man: In this case, if someone went *aeo sao*, the result of the blood test in the following day won't tell that he has AIDS or not then.
2nd man: Absolutely not, you have to wait for 45 days before having a blood test.
Headman: Yes, the disease needs some time to multiply. Those who die from AIDS in recent years probably have had AIDS five years ago.

Urban village, married men

9 People usually used the term AIDS in referring to people with HIV or in referring to the virus itself. The term 'HIV infection' was not practically used in the discussion among the general village community.

Table 8.4 Per cent distribution according to perceived risk of getting AIDS

PERCEIVE SELF AT RISK OF GETTING HIV OR NOT	High risk	Mod risk	Low risk	No risk	Not sure	HOPE TO HAVE HIV BLOOD TEST OR NOT	Yes	No	Total %	N
SINGLE MEN						SINGLE MEN				
Without sexual experience	4	4	12	76	4	Without sexual experience	40	60	100	26
Ever had sexual experience	14	15	12	47	12	Ever had sexual experience	66	34	100	59
Ever had sex with prostitutes						Ever had sex with prostitutes				
last year	15	4	7	52	22	last year	57	43	100	27
within 1-3 years	27	9	9	46	9	within 1-3 years	91	9	100	11
more than 3 years	7	29	21	43	0	more than 3 years	71	29	100	14
in lifetime	15	12	12	48	13	in lifetime	67	33	100	52
Total single men	11	12	12	56	9	Total single men	58	42	100	84*
SINGLE WOMEN						SINGLE WOMEN				
Without sexual experience	4	4	11	68	13	Without sexual experience	13	87	100	55
Ever had sexual experience	0	0	50	50	0	Ever had sexual experience	100	0	100	2
Total single women	4	4	12	68	12	Total single women	14	86	100	57

* Missing case=1.

(continue)

Table 8.4 (continued)

PERCEIVE SELF AT RISK OF GETTING HIV OR NOT	High risk	Mod risk	Low risk	No risk	Not sure	HOPE TO HAVE HIV BLOOD TEST OR NOT	Yes	No	Total %	N
CURRENTLY MARRIED MEN						CURRENTLY MARRIED MEN				
Never paid for sex	3	3	3	91	0	Never paid for sex	46	54	100	39
Had sex with prostitutes						Had sex with prostitutes				
last year	8	0	25	50	17	last year	67	33	100	12
within 1-3 years	4	11	20	61	4	within 1-3 years	68	32	100	28
more than 3 years	2	4	18	68	8	more than 3 years	47	53	100	115
after marriage	4	6	19	64	7	after marriage	61	39	100	75
in lifetime	3	5	19	65	8	in lifetime	52	48	100	155
Total currently married men	3	5	16	70	6	Total currently married women	47	53	100	194
CURRENTLY MARRIED WOMEN						CURRENTLY MARRIED WOMEN				
Believed husband never paid for sex	0	3	8	73	16	Believed husband never paid for sex	29	71	100	67[a]
Believed husband ever paid for sex	6	10	7	55	22	Believed husband ever paid for sex	24	76	100	146
Believed husband stopped paying for sex	5	9	7	60	18	Believed husband stopped paying for sex	22	78	100	125
Not sure whether or not husband still paid for sex	25	25	0	0	50	Not sure whether or not husband still paid for sex	53	47	100	21
Total currently married women	4	7	7	62	20	Total currently married women	28	72	100	246[b]

a Exclude 16 missing cases and 22 women who were not sure whether their husband had ever paid for sex.
b Exclude one missing case and four women who were not sure that they knew well about AIDS.

Table 8.5 Per cent distribution according to reasons for perceived self-risk of getting HIV infection

REASONS FOR BEING AT RISK OF GETTING AIDS OR NOT	Currently married		Single	
	Men	Women	Men	Women
REASONS NOT AT RISK OF GETTING AIDS				
Confident that self is not at risk e.g. never have sex, never paid for sex, have abstained from commercial sex long ago, healthy with no sign of illness	66	59	50	68
Have negative HIV blood test or have donated blood recently	2	2	0	0
Have abstained from having sex with husband for some time	0	1	0	0
Always use condoms with commercial sex when AIDS is known	2	0	6	0
REASONS AT RISK OF GETTING AIDS				
Had paid for sex or not sure whether husband had paid for sex or not	7	8	11	0
There are many people with AIDS so may be contracted in many ways eg. food, drinks, haircut, injection, blood transfusion, helping people in accident	16	8	21	20
Have had close contact with people with AIDS	0	2	1	0
Always use condoms with prostitutes but condoms may break	1	0	2	0
NOT SURE WHETHER AT RISK OF GETTING AIDS OR NOT				
Not sure about husband's behaviour	0	14	0	0
Afraid of condom break	2	0	4	0
AIDS may be transmitted by many other ways e.g. food, drinks, close contact with people with AIDS, haircut, medical injection etc.	4	6	5	12
Total per cent	100	100	100	100
Total respondents	194	246a	84b	57

[a] Exclude one missing case and four women who were not sure they knew well about AIDS. [b] Exclude one missing case.

Table 8.6 Per cent distribution according to reasons for having HIV blood test or not

REASONS FOR HAVING HIV BLOOD TEST OR NOT	Currently married		Single	
	Men	Women	Men	Women
REASONS FOR NOT HAVING HIV BLOOD TEST				
Not necessary because of low risk e.g. have only one partner, have abstained from commercial sex for a long time, have no sex experience	32	51	21	79
Have had the blood test already	14	13	8	0
Have given blood donation recently	4	0	4	0
Do not want to know the result because the disease is not treatable	3	8	9	7
REASONS FOR HAVING HIV BLOOD TEST				
Want to know the result for comfort because self or husband had paid for sex before or because may contract AIDS by many other ways e.g. food, drinks, haircut, medical injection etc.	44	24	57	14
Have physical checkup annually which requires the blood test	2	1	1	0
Receive medical injection frequently	0	0	0	0
Want to have children	1	1	0	0
In case husband has not abstained from commercial sex yet	0	2	0	0
Total per cent	100	100	100	100
Total respondents	194	246[a]	84[b]	57

a Missing case=1, don't know AIDS=4.
b Missing case=1.

Table 8.7 Per cent distribution according to requirement for spouse to have HIV blood test and reasons for having the test or not

DO YOU WANT YOUR PARTNER TO HAVE HIV TEST?	Currently married		Single	
	Men	Women	Men	Women
REASONS WHY HIV BLOOD TEST IS NECESSARY FOR PARTNER				
To feel comfortable that he or she will not contract HIV from partner or to be sure that both of them are not infected	34	34	78	75
Want to have children	4	0	0	0
In case partner had casual sex with other partner	0	9	0	0
Partner receives frequent medical injection	1	0	0	0
Partner donated blood recently	0	2	0	0
HIV blood test was required regularly at partner's work	2	0	0	0
REASONS WHY HIV BLOOD TEST IS NOT NECESSARY FOR PARTNER				
Not necessary because partner not at risk of getting HIV	45	42	22	20
Partner had HIV blood test already	12	9	0	0
Do not want to know the result because AIDS is not treatable	2	4	0	5
Total per cent	100	100	100	100
Total respondents	194	246[a]	47[b]	45[c]

a Missing cases=5
b Missing cases=2, cannot tell now depending on who will be the prospective wife=36.
c Missing cases=2, cannot tell now depending on who will be the prospective husband =10.

8.6 RECENT CONDOM USE

In the absence of a cure or vaccine, condom use is being promoted as an important means of protection against HIV infection. Nevertheless, as reported in the literature, there are several problems with the use of condoms. First, although the prevalence of condom use has increased sharply since the early 1990s as detected from a regular survey by the Ministry of Public Health (Monklavirat and Hanpadungkit, 1993: Figure 5), only half of men of low social class such as conscripts, labourers, construction workers, farmers and truck-drivers, consistently use condoms with prostitutes. The reasons for not using condoms include regarding them as unnatural, forgetfulness, heavy drinking, no fear of disease and sex workers looking clean (VanLandingham et al., 1992; Sawaengdee and Isarabhakdi, 1991; Rojanapithayakorn and Poonpipat, 1991); some prostitutes do not encourage the clients to use condoms (Brinkman, 1992: 24); some of them become sore if they have several clients a night and if all used condoms, some are allergic to lubricated condoms and refuse the use (Yoddumnern-Attig, 1992:52).

Secondly, prostitutes tend to have 'dry sex' with inadequate use of lubricants, or if used, the lubricants are mostly unhygienic substances. In a study of condom use skills among 100 prostitutes and 100 males attending STD clinics, it was found that using lubricants was one of the weakest areas of condom use skill among prostitutes and their customers (Havanon and Ratanapornjaroen, 1990). An application of water-soluble jelly like KY jelly outside and inside the vagina is recommended to make intercourse more comfortable for women with vaginal dryness. Nevertheless, KY jelly is considered expensive among Thais and alternative substances such as body lotion, vaseline, hair cream, saliva and water are commonly used as substitutes among Thai condom users (see case study number 6 in Appendix D) [10]; some prostitutes change to another condom when one becomes dry during intercourse (see Appendix C). Inadequate use of lubricants and use of unhygienic lubricants may in turn lead to irritation and chronic inflammation of the vagina, thus facilitating HIV transmission.

Thirdly, men tend to use condoms with women who are considered to be prostitutes only: however, in some circumstances it may be difficult for them to determine whether or not their partners are prostitutes (see case study number 2 in Appendix E). The condom use rate may be low among women who work as indirect prostitutes, or if the woman was perceived as not promiscuous by nature or if she did not copulate with many men.

Moderator: How are you confident that AIDS can be prevented by condom use?
1st man: Not so sure, sometime they broke.
2nd man: I think condom use is only 70 per cent effective.
Moderator: When do you use condoms?
3rd man: When you have desire, otherwise they won't be erected...how can you wear

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10 Among those reported as using condoms with prostitutes, most said they never used any extra lubrication during intercourse, only three men reported using KY jelly, haircream or vaseline as lubricants sometimes.

condoms then.

Headman: If you have sex with people other than prostitutes, will you use condoms?

4th man: What do you mean?

Headman: Like if you want to play *boo kamin* [or 'a yellow turmeric well' in reference to anal sex with men or transvestites] would you use condoms?

1st man: Condom is needed.

4th man: In my case, if I had casual sex with Mrs A, Mrs B, Mrs C from our village, I won't use condoms.

Everyone: No, no because you know about the background of each other.

1st man: I won't take *kathoeys* [transvestites] though...(laughs)....

4th man: If we know that the woman is promiscuous, we use condoms. Or else why use condoms?

Moderator: You mean it is depending on the type of women that you would have sex with?

Everyone: Of course.

Urban village, married men

8.6.1 Prevalence of Condom Use in the Last Year

The condom use rate among those who had had sex with prostitutes in the last 12 months was high: 92 per cent or all but two of 27 single men who paid for sex in the last 12 months claimed that they used condoms every time when they had sex with prostitutes in the last year. One of the two men said he used condoms most of the time and the other said he used condoms sometimes last year. For currently married men who paid for sex in the last year, about 83 per cent of them or 10 out of 12 currently married men who paid for sex in the last 12 months claimed they had always used condoms with prostitutes every time within the last year. Only one currently married man said he never used condoms and the other said he used condoms sometimes only. The report of high condom use is in agreement with the information obtained from prostitutes and the brothel operators. Under the strong government campaign to promote condom use, the prostitutes receive a box of free condoms when they go for the regular physical checkup: all clients are required to use condoms every time. However, some incidents when condom use was not successful were reported: condom break during intercourse[11]; clients refused to use condoms when they were drunk; some men took off the condoms during intercourse; or clients declined to use condoms in the second sex episode. In addition, condom use was rare when prostitutes had sexual intercourse with boyfriends, many of whom were their regular customers (see Appendix C). Nevertheless, the regular use of condoms had led to discomfort of prostitutes who may later decline the use: some prostitutes were allergic to condoms or lubricants; some had dry sex from lack of extra lubrication; many free condoms were of low quality without lubricant; some women may experience difficulty in washing lubricant from the vagina; or some may feel sore after frequent condom use. Some men perceived that condom use may not be safe enough for AIDS prevention: they believed that condom break might occur during intercourse so it was common that a few condoms were used for extra confidence.

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11 All men, except two currently married men, who reported using condoms with prostitutes in the last 12 months said they had never experienced condom break.

Some said condom use is not safe since the condom does not cover the scrotal sacs so HIV can be transmitted anyway.

8.7 AIDS-PREVENTIVE METHODS IN PEOPLE'S PERCEPTION

From the perceived methods of AIDS prevention shown in Table 8.8, it can be seen that people believed that protected sex with prostitutes or abstinence from casual sex with prostitutes was the only way to prevent the spread of AIDS. Some men believed that HIV would not spread if prostitution were abolished. However, others believed that without prostitution, crime and rape might increase.

Headman: How can we prevent AIDS?
1st&2nd man: Only stop going *aeo sao*.
3rd man: Prevent teenagers from going *aeo sao* or using injecting drug.
Headman: We should also have self control as well.
3rd man: That's true, we should have a good discipline and we should also teach men in the younger generation to avoid going *aeo sao* or using injecting drug too.
Headman: Do you think if the government launched a law to abolish prostitution, will men stop *aeo sao*?
1st man: Of course.
2nd man: But I don't go *aeo sao* now. I have more fear than desire.
Headman: If the government really takes it seriously, I think it is possible to stop men from *aeo sao* but adultery or sexual affair may be increasing.
1st man: We see it happening now. Some people have already set an eye for casual partners.

Rural village, married men

Headman: Should the government have a law to abolish prostitution?
1st man: I don't think so. Raping will be increasing.
2nd man: Not necessary, raping is high these days even though there are many prostitutes available.
3rd man: What do men do when they have desire for sex then?
1st&4th man: Masturbate, help yourself. But a lot of things can arouse your desire though [e.g. pornographic magazines and movies].

Rural village, single men

Headman: Should the government have a law to abolish prostitution?
Everyone: No way.
1st man: If there was no prostitutes, the incidence of raping would be very high. The government can make the law but it won't stop people from going *aeo sao*. It is like making gambling illegal but many people still play it.

Urban village, married men

Table 8.8 Per cent distribution according to AIDS preventive methods

Preventive methods	Women	Men
Men should stop prostitute patronage	52	50
Use condoms every time when having sex with prostitutes	23	27
There is no effective prevention for AIDS	13	1
People with AIDS and HIV should be separated from others	2	4
Prostitution should be abolished	2	4
Give education about AIDS to people at young age	3	5
Others	5	9
Total percentage	100	100
Total number [a]	240	291

[a] This is the total number of people who gave opinions about AIDS prevention. Some people gave more than one answer. About 26 per cent of women and one per cent of men did not give opinions about AIDS preventive methods.

8.8 DISCUSSION

AIDS education has been given to the people by several types of mass media for a long time, and has been crucial in raising AIDS awareness as well as AIDS fear among the people. Although people in the village have a high awareness about AIDS, some of their beliefs suggest need for clarification and correction of knowledge as well as investigation about medical practices in the rural areas. Similarly to their belief about STD prevention, nearly 20 per cent of men and women believed that *coitus interruptus* could prevent HIV infection, which indicates their lack of knowledge about the route of STD infection. It is also believed that HIV may be cross-infected from patient to patient through medical procedures especially at the level of village health stations, where shortage of medical supplies is a common problem.

The prevalence of recent visit to prostitutes was low because men fear getting AIDS; about 32 per cent of single men and six per cent of currently married men reported paying for sex in the past 12 months. The high condom use rate with prostitutes in the past year probably promotes prostitute patronage among some men since the use of condoms gives prostitutes and their clients a false sense of security. In addition, some men perceived that sexual contact with prostitutes may be safer than sexual contact with some non-prostitute girlfriends because prostitutes have regular STD checkups. Although the use of condoms with prostitutes was high and regular, it is not known how long they would maintain the use. Beliefs such as that *coitus interruptus* could prevent AIDS transmission suggest that some men might avoid condoms, especially when they perceive that their partners are less likely to be HIV-infected.

About one-third of men perceived themselves to be at risk of contracting AIDS but their perceived risks were mostly related to minor risks like sharing food or drink, or getting haircuts. Only a few men perceived themselves to be at risk of getting HIV infection from their liaison with prostitutes. A large number of men said they were not at risk of getting AIDS as they had abstained from prostitute patronage long before AIDS became an epidemic. Regardless of their perceived HIV risk, about half of men and one-third of women hoped to have an HIV blood test. The desire for HIV blood tests among people with low risk suggests their fear of AIDS. About 20 per cent of men and women hoped to have an HIV blood test because they believed that they might have contracted HIV from food, drink, haircuts, medical injections and blood transfusion. A number of men and women believed that they were AIDS-free since they believed that their HIV blood tests were taken during pregnancy or blood donation and the results were normal. Abstinence from casual sex with prostitutes and regular condom use with prostitutes were suggested as ways to limit the spread of HIV infection.

CHAPTER 9
Summary and Conclusion

The outbreak of AIDS in the Upper-North region of Thailand through heterosexual contact in recent years has raised many concerns, particularly how the epidemic can be controlled. Although the government has claimed success in controlling the spread of AIDS by high condom use in recent years, the spread of HIV infection continues as shown from the rising prevalence of HIV infection among low-risk populations. To limit the spread of AIDS, it is necessary to find out what factors have caused Thai men to have multiple sex partners. It is remarkable how little has been known about the sexual life of Thais apart from the fact that a large number of Thai men enjoy sexual contact with prostitutes. We have known nothing about how people, particularly those in the rural areas, perceive sexuality, how they form partner relations and how they feel about coitus, body fluids, anatomy or sexual acts. It has not been clearly understood why a large number of married men pay for sex after marriage.

This study explores the socio-cultural factors which influence the partner relations of people in the rural areas of Chiang Mai in relation to the AIDS outbreak. A combination of qualitative and quantitative approaches was used to collect the information over an eight-month period from 1993 and 1994. A life history review was used to collect information from selected individuals followed by face-to-face interviews with about 600 men and women aged 15 to 49 randomly selected from 12 villages. Two villages were further selected for participant observation and 12 group discussions were carried out.

9.1 CHANGES OF PARTNER RELATIONS OVERTIME

The partner relations of Thais comprehend the involvement of men with prostitutes and non-prostitute women. Findings about partner relations in this study can be summarised into the following three periods.

9.1.1 Partner relations before 1960

This is the period when prostitution did not play a significant part in partner relations among people in the rural areas. The establishment of prostitution in Chiang Mai and Bangkok or central Thailand during that time was mainly a part of urban life. People in the rural communities did not have much chance to contact people outside their areas then; therefore, their choice of eligible partners was limited to the selection of those from the same or nearby villages. The selection of partners and the development of partnership of the young people at that time were strongly controlled by their parents and were monitored by people in the community. Belief in supernatural power was used to direct the sexual behaviour of the young people. As a result, men and women were expected to gain sexual experience with their partners only after marriage, and to maintain the monogamous relationship thereafter.

Even if prostitution was available during that time, men from the rural areas would not be encouraged to patronise prostitutes from lack of money and lack of transport to town. Furthermore, they married young so there was no need for them to seek sexual contact with prostitutes.

9.1.2 Partner relations before the emergence of AIDS (1970-1980)

This is the period when several socio-economic factors changed and subsequently promoted the growing demand for prostitution by Thai men. Various kinds of direct and indirect prostitution were introduced and flourished rapidly during this period. It became common behaviour for men to gain their first sexual experience with prostitutes and to continue their visits to prostitutes until marriage. An increasing number of men from the rural areas have access to transport and could afford to pay for sex with prostitutes more than before; hence, prostitute patronage was no longer limited to urban men since it has become an alternative for most men to gain premarital sex with prostitutes. In contrast to men behaviour, women are expected to maintain their virginity until marriage. As a result, men's and women's sexual experience before marriage is different: it is generally accepted that men gain sexual experience with prostitutes, but women are still expected to abstain from sexual contact until marriage. Subsequently, women are classified into two groups: 'the good women' who keep their virginity until marriage and 'the bad women' such as prostitutes or those who have sex with boyfriends before marriage.

Although prostitute patronage had been promoted as common behaviour among Thai men, about half of them would abstain from sexual contact with prostitutes when they are married. The reasons for married men to pay for sex with prostitutes mainly come from friends' influence and social drinking; however, some information about sexual relations within marriage also explains why married men pay for sex. Some wives allow their husbands to have sex with prostitutes because they feel that they cannot satisfy their husband's sexual needs; therefore, prostitution has flourished as an alternative for men to make up for this limitation. According to several beliefs among Thais such as those about sterilisation, sexual operations, and women's attitudes to men's recourse to prostitutes, it can be concluded that Thais believe that men are sexually active but women should be sexually passive, which supports men's contact with prostitutes and consequently increases AIDS risks.

Even though prostitution is believed to have been rare in the Upper-North region before the 1960s, a large number of women who entered prostitution in the subsequent years came from this region. The current establishment of prostitution in Chiang Mai suggests that prostitution has gained its popularity among local men in only a short period of time. The significant value of female virginity has led some women who have lost their virginity with boyfriends or those who have separated from husbands or boyfriends to enter prostitution by their own choice. An increasing number of women from this region

enter prostitution following their friends or relatives who previously worked or currently work as prostitutes to financially support their family.

9.1.3 Partner relations during the current AIDS outbreak (mid 1980 to 1990 onward)

Although the first AIDS case was detected in Thailand in 1984 followed by the subsequent outbreak of HIV infection among high-risk populations such as male and female prostitutes, injecting drug users, prisoners and men with STD, few people in the rural areas were aware of the existence of AIDS until the early 1990s when the strong educational campaigns about AIDS began. However, AIDS emerged in Thailand during the time when a large number of Thai men frequented prostitutes without condom use. The late introduction of AIDS education campaigns led to a rapid transmission of HIV to low-risk populations. One of the reasons for the high prevalence of HIV infection in the Upper-North region is the fact that prostitutes come disproportionately from there. A large number of men in this region acquired HIV infection from unprotected sex with prostitutes in the early years of the AIDS outbreak; currently, they have transmitted the virus to low-risk populations including their non-prostitute partners and wives, and some thus infect their newborn babies.

Although high awareness about AIDS has led to a declining number of men who have sex with prostitutes in recent years, about one-third of single men who are wage earners in the rural areas still do not abstain from sexual contact with prostitutes. Despite their regular use of condoms, it is likely that some men would use condoms only with women who are considered to be prostitutes. However, the lack of certain knowledge whether or not their partners are prostitutes or have had sex with other men makes it difficult for men to consistently use condoms with their partners.

Apart from several factors leading men to pay for sex, the marriage squeeze phenomenon additionally explains why single men seek sexual contact with prostitutes. The division of social classes according to education, occupation, place of residence and economic status is substantial among Thais, and these social divisions consequently limit choice in partner selection for many people. In the near future, Thailand may be facing a 'bi-polar marriage squeeze' in which men from one social extreme and women from the other will have difficulty in finding suitable partners. In comparison to other men, young men from the rural areas are less likely than other men to find suitable partners; thus, their liaison with prostitutes has been promoted. Unless they are married, it is likely that sexual contact of men with prostitutes will continue, especially among men of low social class. Whether or not AIDS treatment becomes available in the future, men who have difficulty in finding a long-term partner will continue their sexual contact with prostitutes.

9.2 CONTRIBUTION TO KNOWLEDGE

The information in this study not only reveals the prevalence and level of sexual behaviour of people in the rural areas but is also useful in yielding insights into their feelings, meanings and expressions of sexuality. Furthermore, while most Thai studies on AIDS and risk have examined the issues narrowly, as with sex with prostitutes, this study looks further into the family-building relationship from courtship to marriage and is able to reveal some of the significant issues which have not been given sufficient attention before.

The sexual culture of Thais was well established long before the time of AIDS, yet none of the current studies on AIDS and heterosexual transmission among Thais has explained how people developed their relationship with the opposite sex before the time of AIDS, or before the time that sexual contact of men with prostitutes had been accepted by people in both the rural and urban areas. From reviews of relevant literature, it was found that the issue of partner relations of *khon muang* had gained much interest with most attentions in two periods of time: first, some anthropological works in the last few decades gave much attention to courtship behaviour of *khon muang* concerning their courtship tradition and their spiritual beliefs in the control of sexual morality; second, the recent outbreak of AIDS in this region had led many social researchers to study the sexual contact of men with prostitutes in relation to AIDS risk. While the former type of study perceives the past courtship tradition of *khon muang* as distinctive, the latter considers that the sexual behaviour of men in this region are similar to men elsewhere in their liaison with prostitutes. However, this study fills a gap in knowledge between these studies by explaining changes of *khon muang* partner relations over time. It explains how prostitution developed in Chiang Mai along with the decline in traditional beliefs and practices among people in the younger generation resulting from recent socio-economic changes. It combines knowledge from fieldwork and data of an anthropological type to explain changes of sexual culture of *khon muang* which have not been given attention before.

This study suggests a potential marriage squeeze on bachelors in the rural area. However, further study will be needed to detect whether or not this phenomenon really exists. To assess the level of the marriage squeeze, the sex ratios of single populations were calculated using the census data from 1960 to 1990. The calculation of sex ratios in this study was stratified into rural-urban residence and level of educational attainment as it was believed that these two factors can be used to indicate meaningful social groups among Thais; subsequently, the formation of social networks within these social groups limits their choice of partner selection for family-building. It was found that the prevalence of men who paid for sex in the most recent year, when AIDS was known, was much greater among single than married men; therefore, it is believed that the majority of married men abstain from sexual contact with prostitutes from fear of contracting HIV. However, a number of single men continued to have sexual contact

with prostitutes as they believed that condom use can prevent them from getting HIV. It was expected that, if they had difficulty in finding a long-term partner, single men would continue to have sexual contact with prostitutes whether or not AIDS treatment becomes available. Men from the low social class are likely to continue their sexual contact with prostitutes because some of them have difficulty in finding suitable partners.

Although this study confirms the findings of other studies that a large number of Thai men have sexual contact with prostitutes and a small number of them have sexual contact with non-prostitute partners, this study shows that 80 per cent of men aged 15 to 49, randomly selected from the villages in Chiang Mai, have had sex with prostitutes in their lifetimes. Most importantly, the prevalence and level of sexual contact of men both before and after marriage which was not available in earlier household surveys (Sittitrai et al., 1992; Guest and Thongthai, 1995) is now available in this study. About 35 per cent of currently married men have had sex with non-prostitute partners before marriage. A large number of them ceased their sexual contact with prostitutes once they were married; however, about 40 per cent occasionally had sexual contact with prostitutes and seven per cent had sexual contact with non-prostitute partners apart from wives. The median number of times that men had sex with prostitutes before marriage was 15 times.

In survey-type studies, there has been a discrepancy in reporting between men and women about the number of sex partners that they have before marriage. In this study while one-third of currently married men claimed to have had sex with non-prostitute women other than their wives before marriage, only one per cent of women claimed to have had sex with men other then their husband before marriage. Although a specific study design is needed to identify the characteristics of those women who have sex with men without marriage, it was found that, from the life history reviews of prostitutes, women in this group are direct and indirect prostitutes who tend to move in and out of marriage life several times. Other women in this group are single non-prostitute women who have sex with their boyfriends because they expect to marry or to live with their boyfriends for a long term.

In keeping with a recent study on Thai views of sexuality using qualitative methods (Knodel et al., 1996), the findings of my study strongly support the notion that men have a greater sexual need than women and women viewed their own sexuality as a means for providing satisfaction for their husbands' need. In addition to information from group discussions, all findings from my study about sterilisation, traditional sexual operations and perceptions about sexuality support the general perception among Thais that men and women are different by nature in their sexual needs. In agreement with Knodel et al., this study found that sexual abstinence with wives during pregnancy led some men to seek sex with other women during that period. Furthermore, this study suggests that the average duration of childbirth-related sexual abstinence was five months, and the prevalence of men who had sex with women other than their wives during this period was 20 per cent. Most of their sex partners were prostitutes. Additionally, this study

found that some women in the Upper-North area can use their postpartum symptoms to refuse coitus with husbands.

From historical data, this study provides information about Thai views of sexuality based on knowledge about male and female sexual operations such as penile pearls, circumcision and vaginal cleansing. This study shows the contemporary use of penile pearls, which the history literature assumed no longer existed after the seventeenth century, and reveals it as a current practice adopted by men to increase their manhood. My study found that men indulge several kinds of sexual operations, not only penile pearls, to make up for the fact that some women were likely to suppress their feelings of sexual arousal, not because women demanded that they have the operation to sexually please the women as is claimed in the historical literature.

9.3 SUGGESTED INTERVENTIONS AND POLICY IMPLICATION

9.3.1 Improved quality of AIDS awareness

Many collective beliefs about AIDS reported in this study suggest the necessity to set up counsellors for AIDS-related inquiries accessible at the village level. Although a large number of village health volunteers and village health reporters in Thailand have opportunities to attend workshops about AIDS education, they may be incompetent to clarify people's doubts about AIDS. As shown in this study, myths and beliefs about AIDS occur together with people's lack of knowledge about related subjects such as sexuality and family planning. It may be necessary to establish the AIDS counselling office as a mobile unit providing people in the remote areas with counselling as well as education.

9.3.2 Necessity of marriage guidance and relationship counselling

Despite the high prevalence of premarital sex, divorce, rape, abortion, minor wives and prostitution in Thailand, little effort has been made to help people in the younger generation to deal with difficulties in partnership development. An increasing number of young people have moved away from their traditional family support system and lack family support in their relationships with the opposite sex. Hence, it seems necessary that guidance and counselling from external sources about marriage and partnership development should be made available for young people. From fear of contracting AIDS, it is likely that young men, particularly students, have postponed their sexual experience until a later age than before. They are also more likely to have sex with girlfriends, not prostitutes; hence, premarital sex between men and non-prostitute women has become increasingly common. Those who engage in premarital sex may also need guidance to deal with their situations such as their risk of getting AIDS or becoming pregnant.

Although premarital counselling has been introduced in Thailand in recent years in a few major hospitals, the scope of the service is limited to the detection of inherited diseases of the couples before marriage. The existing service is limited since it is bound to hospital management, and is dominated by medical staff. It may be useful to introduce a trial 'family counselling' clinic, or expand the role of the existing anonymous clinic for HIV tests and counselling to cover related subjects. The counsellors of these clinics should be able to discuss with their clients the general issues such as relationship formation, marriage guidance, sexuality, family planning, and AIDS. At the present time, people who seek external support for relationship development are left to depend on some magazine and newspaper columnists who have assumed the role of relationship counsellors.

9.3.3 Necessity to change men's and women's attitudes to sex

Findings of this study suggest that people's attitudes to sex need to be changed and the government should not promote the AIDS education or prevention campaigns that promote the perception that men are obsessed with sex. The promotion of condom use was the first step in dealing with the AIDS crisis in Thailand followed by emphasis on the idea that people could enjoy the same sexual pleasure with condoms as without them. To promote condom use, a few well-known AIDS organisations in Thailand have emphasised that prostitutes should be given knowledge how men can be sexually satisfied using condoms. Even though the use of condoms has increased sharply and could prevent the spread of HIV to some extent, a number of men continue to have sex with prostitutes, and many more who have currently suspended their prostitute patronage probably resume their sexual contact with prostitutes when they feel that they are safe from getting AIDS through using condoms. The false sense of security of condom use may bring back the previous high prevalence of prostitute patronage among Thai men whether or not AIDS can be cured. Although the use of condoms is essential and needs to be continuously promoted, change in social values, by encouraging men to have sexual contact with one partner at a time, needs to be promoted among Thais as well.

9.3.4 Promote sex education and counselling

Sex education at school is too late for the present sexually active generation, but may help the generations of the future to have a better understanding of sexuality. Along with an emphasis on relationship counselling, sex education at school should be promoted with appropriate content. The emphasis of sex education should not be mainly on sexual intercourse, contraception or prevention of AIDS as it is currently; in addition, it should stress the importance of emotional development and responsibilities of men and women in forming a relationship rather than focusing on sexual contact.

Apart from education at school, sex education should be given to women as part of their general knowledge about women's health. Because the interest in sexual matters among Thai women is supposed to be restrained, sex education for them should be integrated as a part of their education about women's health. From lack of knowledge about women's health, women in the rural areas have several kinds of myths and beliefs about their emotional and physical changes at different stages of their life; consequently, such beliefs could affect their sexual relations within marriage and promote prostitute patronage by their husbands.

9.3.5 Prevention of AIDS outbreak in the long run

The use of condoms is not the answer to the AIDS crisis in Thailand in the long run. Because of the availability of condoms, a number of single men continue to pay for sex: indeed, Thai men use condoms only with prostitutes, but not with their non-prostitute partners. The sex culture in Thailand encourages men to freely indulge in sex, even though HIV infection spreads with no cure. The real solution to the spread of HIV is to promote sexual relations within unions and upholding family values in which men and women have only one partner at a time.

While Africa has more AIDS cases than any other continent, Asia is set to overtake it with the majority of the cases in India and Thailand. UNAIDS found that poverty was one of the most powerful forces driving the spread of HIV infection (*Reuter news*, 28 April, 1996). This claim seems to be invalid in the case of Thailand since the country has experienced rapid economic growth in recent years. However, the recent economic growth in Thailand has brought about extremely unbalanced income distribution between the rich and the poor. The division of social networks by education and economic status of the people has become increasingly significant and subsequently leads to difficulty for some people in finding suitable partners.

Comparing between Thailand and India where the number of HIV cases is the highest in Asia, these two countries share some similarities which promote the sexual contact of men with multiple partners. Prostitution in Thailand and India dates back through history and has retained its significant role in providing men with sexual pleasure. These two countries are also similar in the division of social networks among people from different social classes. Even though Thais no longer conform to the hierarchy of the social classes as in the old times, the different status of the people at present can be classified by their wealth. The likelihood of social division among Thais is more or less like caste system in India by which people are pressed to select their partners from their own caste. The division of social networks among people from different social classes will limit the adjustment of the unbalanced marriage market. Consequently, a number of single men from the low social class will be pressed to continue their sexual contact with prostitutes.

There have been several efforts and movements in Thailand to bring about the equity of people in urban and rural areas. The recent movements such as the Population and Community Development (PDA) led by Mr. Mechai Viravaidya have progressed in the right direction to terminate the spread of AIDS in the long run. In the past ten years, PDA has encouraged a large number of private companies in Thailand to invest in the rural areas by supplying people in the villages with technical knowledge and skills enabling them to be company workers without any need to come to the city for jobs. PDA is trying to promote urban-style jobs for people in rural areas except that people stay in their village for the jobs yet receive similar incomes to those for urban jobs. Thus, people in the rural areas can remain living with their family in the village and also women are not encouraged to enter prostitution to financially support their family.

9.4 SUGGESTIONS FOR FURTHER RESEARCH

Many Thai studies have given attention to men's liaison with prostitutes but there has been little focus on the development of partnerships between men and their non-prostitute partners including wives and other non-paid women. Although this study has shed light on sexual relations within marriage and perceptions of men and women about sexuality, it lacks information about single women who have sexual relations with their boyfriends before marriage. A large number of men have abstained from sexual contact with prostitutes in recent years from fear of contracting HIV; however, there is a tendency for an increasing number of them to have sexual contact with non-paid partners without condom use. Knowledge about the relationships between men and non-prostitute partners is essential. Some description of the characteristics of women in this group will provide useful knowledge. Their sexual networks and the stability of their relationships need to be explored.

This study suggests that even though a majority of men have had sexual experience with prostitutes, about one-fifth of them have neither had sex with prostitutes nor with any women other than their wives. It is worth finding but why this group of men do not have several female partners like other men. Study of the characteristics and attitudes of men who have monogamous relationships will provide a new perspective of knowledge about partner relations suggesting why they do not pay for sex or do not have sex with any women other than wives. The information obtained will be useful for the promotion of family values and monogamous relationships among Thais.

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Appendix

A

Male and Female Questionnaires

Survey of Health and Partner Relations
Male Questionnaire

Wassana Im-Em
National Centre for Epidemiology and Population Health of
Australian National University

Number of the Questionnaire.....
Date of the interview.....
Name of interviewer.....

- Instruction for interviewers

1. Circle the choice of answer given by the respondents. If the answer is not available, describe the answer in OTHER.....
2. Keep the interview short at no more than 40 minutes
3. Select a private area for the interview.
4. The interviewer must understand the questionnaire before using it. Ask questions in order as listed. Do not ask several questions together at the same time because you may be confused with sequence of the questions.
5. After completing the interview, check all answers again. Answer every question and check whether the right answers are written. If not all questions are completed, you need to reinterview the respondents to complete the questionnaire.
6. Revisit the same house if the respondents are not available. Cancel the interview after two revisits. Do not select people from another household for replacement.
7. Always keep the information secret.

- Introduction to any adult when at the selected households

Sawasdee. My name is..... I am working for Khun Wassana Im-Em who is a Ph.D. student exploring about the health and partner relations of people in the Chiang Mai villages. We would like to interview about 600 people selected from 12 villages of Sansai, Maerim and Sanpathong districts. The information obtained from you will be useful for the improvements of people's health status. In the past two weeks, Khun Wassana has informed your village head about the survey and has received permission from the district and the village head for data collection in this village. All adult men and women aged between 15 and 49 in one of every fourth randomly selected household are targeted for a personal interview. During the interview, we would like to talk to the respondents in private because we will ask them some private questions about partner relations. Now, I would like to get some information about all people living in this house please. [Interviewer: complete the household listing form on the first page of the questionnaire. Then, ask whether any eligible respondent is available for the interview at this time].

- Introduction to the eligible respondent

[Interviewer: repeat the above introduction to the respondents]. I would like to talk to you for 30 minutes about your health and your relationship with the opposite sex. Many of these questions are private but I would like to ensure that all answers will be confidential. If you do not feel like answering any questions, please feel free not to answer. During the interview, I will take notes from time to time. The information that you give will help us to understand how men and women form a relationship with the opposite sex. Some questions will ask your attitudes about the STD infection and AIDS and your responses to the outbreak of AIDS. Your identity will not be identified anywhere. I would like to reassure you before we start the interview that nobody will know what are your answers. All answers are confidential.

HOUSEHOLD LISTING FORM

Village name.....

House number.....

Number of household members: .....persons: .....men .....women

USUAL RESIDENTS OF THE HOUSEHOLD

Coding for relation with head of HH

1 Head of HH

2 Husband/wife

3 Son/daughter

4 Parents of self

5 Parents of spouse

6 In law

7 Cousin/niece

8 Other

No.	Name	Age	Sex	Marital status	Relation to HH head	Eligible for interview
1						
2						
3						
4						
5						
6						
7						
8						

Total number of men and women aged 15-49 in this household is..... persons

RESULT OF THE INTERVIEW

Coding for results

1 Completed

2 Refuse

3 Not at home

4 At home but unavailable for interview

5 Other.....

No	First visit		Second visit		Third visit	
	Date	Result	Date	Result	Date	Result

Survey of Health and Partner Relations

Male Questionnaire

SECTION 1: Socio-economic characteristics of respondents

101. How old are you?

Age in .....years.....months

102. Where is your home origin?

1. Chiang Mai city
2. Rural areas of Chiang Mai
3. City of other province.....
4. Rural areas of other province.....

103. What level did you complete education?

1. Primary school 1 2 3 4 5 6 7
2. Secondary school 1 2 3 4 5 6
3. University 1 2 3 4 5
4. Diploma degree 1 2 3 4 5
5. Other.....

104. After age 15, have you ever migrated to live in province other than Chiang Mai?

1. No----------go to 106
2. Yes

105. Where did you migrate to, and for how long? (Interviewer: write down the place that the respondent has stayed for the longest time).

1.1 Rural area of province.....

Urban area of province.....

1.2 Length of stay.....years

1.3 Reason for migration
1. Education
2. Job related
3. Follow parents
4. Other.....

106. How many siblings do you have who are still alive?

.....brothers

.....sisters

107. Your current occupation is:

1. Government official
2. Farmer/agriculturist
3. Construction worker
4. Student
5. Trade or merchandise related
6. General wage employer
7. No occupation
8. Other.....

SECTION 2: Characteristics of spouse

201. Have you ever married or have you ever been living with a woman as husband and wife?

1. Never, still single-------go to Section 3

2. Yes,------The current marital status is 2.1 Widowed----------go to Section 3

2.2 Separated or divorced----go to Section 3

2.3 Married which is the .....times of marriage

202. How long have you been living with current wife?.....years.....months

203. How old were you when married, and how old was your wife?

Self age.....years.....months

Wife's age.....years.....months

204. What level did your wife complete education?

1. Primary school 1 2 3 4 5 6 7
2. Secondary school 1 2 3 4 5 6
3. University 1 2 3 4 5
4. Diploma degree 1 2 3 4 5
5. Other.....

205. The current occupation of your wife is

1. Government official
2. Farmer/agriculturist
3. Construction worker
4. Student
5. Trade or merchandise related
6. General wage employer
7. No occupation
8. Other.....

206. Within the past year, how often per month do you have sexual intercourse with wife?

Coital frequency is.....times per month

207. Within the past year, what kind of birth control methods do you use most?

01 No method
02 Birth control pills
03 Birth control injections
04 Female sterilisation
05 Male sterilisation
06 Condom
07 IUD
08 Spermicidal
09 Safe period
10 *Coitus interruptus*
11 Other.....

208. Within the past year, have you ever used condoms with wife?

1 Never

2 Yes 2.1 How often.....

2.2 Reason for using condom with wife.....

209. How many children do you have

.....son.....daughter

210. How would you describe your relation with husband?.....

SECTION 3: Relationship with girlfriend or lover (who are not prostitutes)

The following questions ask about the women that you are currently engaged with apart from your wife or prostitutes you may have.

301. Within the past two years, do you have any women that you have been involved with? These women are those you are interested in but have not yet spent life with?

[Interviewer: explain further to married men----this question asks, apart from your current wife, do you have any other women that you are currently involved with?]

1. No----------go to Section 4
2. Yes, total number of women that you have been currently involved with is ..... women

Next questions ask about the latest woman or girlfriend that you have an involvement with in the last two years only.

302. What does this woman do as an occupation .....

303. What kind of relationship do you expect from getting involved with this women?
1. Very much want a marriage
2. Not sure yet, would like sometime to know more about each other
3. No expectation, just play around from boredom
4. Other.....

304. Have you had coitus with this woman?

1. Never----------go to Section 4

2. Yes, the number of coitus is .....times

305. What method do you use to protect this woman from pregnancy?

01 No method	07 IUD
02 Pill	08 Spermicidal
03 Injection	09 Safe period
04 Female sterilisation	10 *Coitus interruptus*
05 Male sterilisation	11 Other.....
06 Condom	

306. When was the last time you had coitus with this girlfriend?

.....(answer in week, month or year).

307. Have you ever used condoms with this woman? If ever used, what was the reason for using condoms?

1. Never----------go to 310

2. Yes, reason for using condoms was.....

308. How often do you use condoms with this women?

1. Every time	3. Often
2. Sometimes	4. Rarely use

309. Who demands the use of condoms, you or your girlfriend?

1. Yourself	2. Girlfriend	3. Both

310. Do you think that this girlfriend has sexual relations with men other than you or not?

1. Yes 2. No 3. Not sure

SECTION 4: Source of knowledge about sexuality

401. Who can you talk to about sexuality?

1. Never talk to anyone
2. Has no one to talk to
3. Public health staff
4. Wife or girlfriend
5. Friends
6. Other.....

402. Do you have any problem with sexual intercourse?

1. No----------go to 404
2. Yes, the problem is .....

403. Have you ever discussed with anyone about this problem?

1. Never talk to anyone
2. Has no one to talk to
3. Public health staff
4. Wife or girlfriend
5. Friends
6. Other.....

404. You learn about sexuality from what source of knowledge?

1. Magazines or newspaper.....A lot Average Little
2. Movies or video.....A lot Average Little
3. Discussion with friends.....A lot Average Little
4. TV/radio program.....A lot Average Little
5. Others, include.....A lot Average Little

405. What are your opinions about the following statements

	Most agree	Agree	Not sure	Disagree	Most disagree
1. Women should keep their virginity until marriage.					
2. Women should marry a man to whom they have lost their virginity.					
3. Women lack source of knowledge about sexuality.					
4. Women should be provided with knowledge about sex before marriage.					
5. Thai people need access to sex education					

SECTION 5: Sexual contact with women

501. How old were you when you first experience a physical display of attraction to the opposite sex such as kissing, cuddling, fondling (apart from paid partners). I mean you were physically engaged with this woman but did not have coitus yet.

Age.....years

If never has a girlfriend----------go to 504

If never has sexual contact with girlfriend----------go to 504

If had coitus at first sexual contact----------go to 504

502. How long do you know this woman before you have such experience?

Duration .....(answer in week, month, year)

503. Who is this woman?

1. Current or previous wife
2. Casual girlfriend
3. Current or previous girlfriend
4. Other.....

504. At what age did you have the first coitus?

Age .....years

If never have coitus, go to Section 8

505. Who is the first woman that you had coitus with?

1. Current or previous wife
2. Current or previous girlfriend
3. Casual girlfriend
4. Prostitute or paid partner------go to 507
5. Other.....

506. How long do you know this woman before you had the first coitus?

Duration.....(give answer in weeks, months, or years)--------go to 508

507. At what age did you have first coitus with non-prostitute women?

1. Age.....years

If only had coitus with prostitute, go to 508

2. Who is this woman?
    1. Current or previous wife
    2. Current of previous girlfriend
    3. Casual girlfriend
    4. Other.....
3. How long did you know this woman before having first coitus.....

508. When you experienced first coitus, were you still a student or had already been married? Did you live with your parents then?

1. Student, lived with parents
2. Student, did not live with parents
3. Not student, lived with parents
4. Not student, did not live with parents
5. Married
6. Other.....

509. How many virgin women have you had sexual intercourse with?

1. None
2. Not sure whether partners are virgins or not
3. Not sure how many virgins had coitus with
4. A total of.....women who are virgins

510. Is it necessary that the women you are going to marry must be virgins before marriage?

1. Not necessary
2. Yes, very necessary
3. Not sure

511. During your wife's last childbirth, did you abstain from coitus with your wife during pregnancy and/or after childbirth?

1. Have no children--------go to 513
2. Not abstained before childbirth, abstained after childbirth for.....months
3. Abstained before childbirth.....months, abstained after childbirth.....months
4. Abstained before childbirth.....months, not abstained after childbirth

512. Did you have coitus with any women other than wife during wife's last pregnancy?

1. No
2. Yes, this woman is.....

513. When was your last coitus?

.....days.....weeks.....months.....years

514. Who was the partner of your last coitus?

1. Wife
2. Prostitute
3. Others.....

SECTION 6: Sexual contact with prostitutes

601. Have you ever had sexual intercourse with prostitutes or women that you have to pay or give something to in exchange for sex?

1. Never----------go to 611

2. Yes

602. What was the last place that you paid for sex services?

1. Brothel
2. Karaoke club
3. Escort women
4. Massage parlour
5. Restaurant
6. Other.....

603. How much did you pay for the last commercial sex?

Cost .....baht

604. When was the last time you had had sex with prostitutes?

.....week.....month.....year

If the answer is more than one year, go to 608

605. Within the last year, how many times did you pay for sex with prostitutes?

A total number of .....times

606. Within the last year, how often do you use condoms with prostitutes?

1. Never use----------go to 608

2. Not often

3. Sometimes

4. Almost every time

5. Every time

607. Within the last year, did you experience any condom break?

1. No
2. Yes, ...times

608. Do you usually use any extra lubricants other than what comes with the condoms?

1. Never use
2. KY jelly
3. Hair cream
4. Olive oil
5. Body lotion
6. Vaseline
7. Saliva
8. Other.....

609. The total number of times that you have had sex with prostitutes in a lifetime is about.....times

- The number of times that you had sex with prostitutes <u>before marriage</u> is about.....times
- The number of times that you had sex with prostitutes <u>after marriage</u> is about.....times

610. Have you stopped having sex with prostitutes?

1. No, not yet
2. Yes, the length of time that I have abstained from commercial sex is.....(write answer in months or years).

611. The total number of women, other than prostitutes and wife for those married, that you have had sex with in a lifetime is about.....women.

- The number that you had sex with before marriage is about.....women
- The number that you had sex with after marriage is about.....women

SECTION 7: Sexual health

701. How do you see your health at this age?

1. Very good
2. Good
3. Moderate
4. Not so good
5. Poor

702. Have you ever had sex with women who put something inside the vagina before coitus?

1. Never
2. Yes
   - 2.1 The material used is.....
   - 2.2 Who is this woman.....
   - 2.3 Reason of the practice.....

703. Do you think that your wife (or girlfriend for single men) objects to the seminal fluid that comes out during intercourse?

1. Not at all
2. Not sure
3. Not much
4. Somewhat
5. Very much

704. Have you ever implanted beads or *fang-muk* in the penis?

1. Never
2. Yes
   - 2.1 The material used is.....
   - 2.2 Reason for the operation.....

705. Do you have any friends with penile implant?

1. No
2. Yes, I have .....friends with penile implants

706. Are you circumcised?

1. No----------Do you want to be circumcised?
   1. No
   2. Yes
2. Yes----------Reason for circumcision
   1. Constricted foreskin
   2. Islamic religion
   3. To increase penis size
   4. Advised by public health staff
   5. Other.....

707. In your opinion, why do men need to be circumcised?

1. Constricted foreskin
2. Islamic religion
4. Advised by public health staff
5. Other.....

3. To increase penis size

708. Do you know a sectional circumcision which may be called Benz circumcision?

1. No----------go to 714

2. Yes, and I have the operation

3. Yes, but I do not have the operation

709. Reason for men to have Benz circumcision

1. To please women

2. To enhance sexual pleasure

3. Other.....

710. How many of your friends have Benz circumcision?

1. None

2. About.....of my friends have this circumcision

711. Have you ever had sexually transmitted diseases?

1. Never----------go to Section 8

2. Yes, a total of.....times

STD infection <u>before marriage</u> was .....times

STD infection <u>after marriage</u> was.....times

712. Do you regularly take medicines to prevent yourself from getting STD?

1. No

2. Yes, the medicine is.....

713. Do you regularly use the following method to prevent an STD infection?

	Yes	No
1. Urinate right after intercourse		
2. Cleansing with solution which is .....(give name)		
3. *Coitus interruptus*		

714. How do you usually treat yourself when infected with STD?

1. Seek medical treatment at.....

2. Self-treatment by.....

715. Within the past 12 months, were you infected with STD?

1. No

2. Yes,.....times

SECTION 8: Perceived risk of getting HIV infection

801. Do you think how much you are at risk of getting HIV infection? Why?

1. High risk
2. Medium risk
3. Low risk
4. No risk
5. Not sure
6. Other

Because.....

.....

802. Would you like to have an HIV blood test? Why?

1. No
2. Yes

Because.....

.....

803. Would you like your wife (or future bride for single men) to have an HIV blood test?

1. No
2. Yes

Because.....

.....

804. What are your opinions about the following statements?

	Most agree	Agree	Not sure	Some disagree	Strongly Disagree
1. *Coitus interruptus* protects one from HIV infection.					
2. I am able to abstain from having sex with prostitutes at all times.					
3. I am able to abstain from having casual sex with casual women at all times.					
4. The inability of wives to sexually please their husbands is one of the factors leading men to pay for sex with prostitutes after marriage.					
5. I would prohibit my sons from recourse to prostitutes.					

805. In your opinion, how can we stop the outbreak of AIDS in our society?

.....

.....

.....

.....

.....

Survey of Health and Partner Relations

Female Questionnaire

The first four sections of the female questionnaire are parallel to those in the male questionnaire

SECTION 5: Sexual contact with the opposite sex

The following questions ask about your personal affairs with the opposite sex. Please feel free not to answer any questions that you may feel offensive.

501. At what age did you first experience the physical display of affection such as kissing, fondling or cuddling by men.

Age.....years

Never have boyfriend.....go to 701

Never have such experience.....go to 701

502. How long do you know this boyfriend before having this first sexual contact?

.....months.....years

503. Who is this man?

1. Current husband
2. Previous husband
3. Current boyfriend
4. Previous boyfriend
5. Other.....

504. At what age did you experience first coitus?

Age.....years

Never have coitus---------go to 701

505. Did you have coitus at the time that you had first sexual contact?

1. No
2. Yes---------go to 508

506. After experienced first sexual contact, how long did it take to experience first coitus?

Duration.....

507. Is the partner of your first sexual contact and that of your first coitus the same person?

1. No
2. Yes

508. Did you marry to the man of first coitus?

1. No------go to 510
2. Yes-----go to 510

509. Who was your partner at first coitus?

1. Current husband
2. Current boyfriend
3. Friend
4. Previous husband
5. Previous boyfriend
6. Other.....

510. Did you have first coitus before or after marriage?

1. Before marriage for.....month.....year
2. After marriage
3. Did not marry the man of first coitus

511. How long did you know this person before first coitus?

.....months.....years

512. When you had experienced first coitus, were you still a student, or had already been married? Did you live with parents then?

1. Student, lived with parents
2. Student, did not live with parents
3. Not student, lived with parents
4. Not student, did not live with parents
5. Married
6. Other.....

513. For your last childbirth, did you abstain from having sexual intercourse during pregnancy or at the period after childbirth?

1. Have no children
2. Not abstained before childbirth, abstained after childbirth for.....months
3. Abstained before childbirth.....months, abstained after childbirth.....months
4. Abstained before childbirth.....months, not abstained after childbirth

514. Do you think that your husband had sex with other women during the period that you abstained from having sex with him at last pregnancy?

1. No
2. Not sure
3. Yes, this woman is believed to be.....

SECTION 6: Sexual relations of husbands with prostitutes

601. Do you think that your husband ever had sex with prostitutes or not?

1. Never ---------go to Section 7
2. Yes

602. Do you think your husband has stopped recourse to prostitutes?

1. Not yet
2. Not sure
3. Yes, stopped since marriage
4. Yes, stopped since.....months.....years

SECTION 7: Sexual health

701. How do you consider your health status at this age?

1. Very good
2. Good
3. Moderate
4. Not so good
5. Poor

702. Do you experience any abnormality with leucorrhoea or menstruation?

1. No
2. Yes, which is.....

Questions 704 to 714 ask only women with sexual experience. For those without sexual experience go to section 8.

703. Have you ever used anything to facilitate coitus?

1. None
2. KY jelly
3. Hair cream
4. Body lotion
5. Vaseline
6. Other.....

704. Do you object to the seminal fluid of husband during intercourse?

1. Not at all
2. Not much offended
3. Not sure
4. Somewhat offended
5. Very much offended

705. Have you ever inserted fingers to clean the seminal fluid from vagina?

1. Never---go to 707
2. Yes

706. After coitus, have you ever adopted the following methods for vaginal cleansing?

	Never	Not frequent	Often	Always
1. Inserted finger to clean vagina				
2. Douching with commercial solution				
3. Douching with tap water and tube				

707. Have you ever heard about penile pearls or *fang muk*?

1. No------go to 708
2. Yes

708. Do you know why men adopt this practice?

.....

709. Is your husband circumcised?

1. No
2. Yes

2.1 Would you like your husband to be circumcised?

1. No
2. Yes
3. Not sure

2.2 Why do you want husband to be circumcised?

.....

710. Why are men circumcised?

.....

711. Have you heard about segmental circumcision or Benz circumcision?

1. No
2. Yes, reason for the practice is.....

712. Have you ever been infected with STD?

1. Never--------go to Section 8
2. Yes, a total of.....times

STD infection <u>before marriage</u>.....times

STD infection <u>after marriage</u>.....times

713. How do you get treatment for STD?

1. Seek professional treatment at.....
2. Self-treatment by.....

714. In the past 12 months, have you been infected with an STD?

1. No

2. Yes, a total of .....times.

SECTION 8: Perceived risk of getting HIV infection

801. Do you know how much you are at risk of getting HIV infection? Why?

1. High risk
2. Medium risk
3. Low risk
4. No risk
5. Not sure
6. Other

Because.....

.....

802. Would you like to have an HIV blood test? Why?

1. No

2. Yes

Because.....

.....

803. Would you like your husband (or future groom for single women) to have an HIV blood test?

1. No

2. Yes

Because.....

.....

804. What are your opinions about the following statement?

	Most agree	Agree	Not sure	Some disagree	Strongly Disagree
1. *Coitus interruptus* protects one from HIV infection.					
2. The inability of wives to sexually please their husbands is one of the factors leading men to pay for sex with prostitutes after marriage.					
3. I would prohibit my sons from recourse to prostitutes.					

805. In your opinion, how can we control the spread of the AIDS epidemic in our society?

.....

.....

.....

.....

Appendix

B

List of questions for group discussions

The questions for group discussions of married men and married women, and of male and female students are parallel; thus, only questions for married women and female students are given.

GROUP DISCUSSIONS OF MARRIED WOMEN

1. Partner selection and marriage
   - 1.1 What should women consider when they have boyfriends?
   - 1.2 How did people in your generation form a relationship with boyfriends? How would you describe courtship in the past? How is it different from the present?
   - 1.3 Is it necessary that women should be virgins at marriage? Is female virginity important?
   - 1.4 What do you think about premarital sex? Was premarital sex scarce in the past? What factors prevented premarital sex in the past?
   - 1.5 How long does it usually take men and women to know each other before marriage? How long should it take? How long did you know your husband before marriage?
   - 1.6 Is it common to marry someone from the same or the nearby village? Have many people moved out of the village after marriage?
   - 1.7 What qualifications should women consider when they select husbands?
   - 1.8 Do you consider that the economic stability of the husband, or of his family, important for marriage?
   - 1.9 How does men's behaviour change after marriage? How about women's behaviour? What factors lead to these changes?
   - 1.10 What are the common conflicts which lead to arguments between husbands and wives?

2. Sexual relations
   - 2.1 Can wives refuse sexual intercourse with husbands? For what reasons?
   - 2.2 Has sexual relations between husbands and wives changed with increased age?
   - 2.3 Do women have sexual needs? What are the differences between men's and women's sexuality? Is it possible for men to abstain from sex? How about women?
   - 2.4 What sort of sex problems occur between husbands and wives? Is sex in marriage important?
   - 2.5 Do you discuss with your children about sex education? What did you tell them? How did your parents discuss with you about sex?
   - 2.6 Have you heard of any methods that men may use to stimulate sexual intercourse? What are they? Why are they used? Do women have any parallel practice?

3. Family planning
   - 3.1 Is birth control necessary? What are the popular methods? Why are they popular or unpopular? What method do you use?
   - 3.2 Do you feel that any methods of birth control affect your sexuality? How?
   - 3.3 Why is male sterilisation not popular?
   - 3.4 Can sterilisation effect sexuality? How? What are the differences between male and female sterilisation?

4. Prostitute patronage
   - 4.1 Why do men have sex with prostitutes?
   - 4.2 Why do some men pay for sex after marriage?
   - 4.3 On what occasions do single men go to prostitutes? How about married men?
   - 4.4 Do you think your husband ever had sex with prostitutes? Why or why not? Do you think your husbands have ceased their visits to prostitutes? How do you know?
   - 4.5 Do you oppose prostitute patronage by single men? How about by married men?
   - 4.6 Is drinking common for men? Does it usually lead men to brothels?
   - 4.7 What occasions do people drink in the village? Do women drink like men?

5. Extramarital affair involving non-prostitute partners
   - 5.1 Why do married men have sexual affairs with other women? Who are these women? What do they expect from the extramarital affair?
   - 5.2 Why do some women become minor wives? Do any men in this village keep minor wives? Who are these women?
   - 5.3 Is casual sex contact of men with non-prostitute women threatening marriage?

6. Response to AIDS
   - 6.1 When were you aware of AIDS? How do people in the village respond to the AIDS outbreak?
   - 6.2 How can AIDS be transmitted?
   - 6.3 Has prostitute patronage declined with AIDS outbreak? When did men stop going to brothels? What kinds of men continue to have sex with prostitutes?
   - 6.4 What will you do if you suspect that your husband may have had sex with prostitutes? Would you ask him to use condoms?
   - 6.5 What kind of people are at risk of getting AIDS? Between men and women, who are at greater risk of getting AIDS? Why?
   - 6.6 Would you like to have an HIV blood test? Please give the reasons.
   - 6.7 Do you perceive yourself to be at risk of getting AIDS?
   - 6.8 How can we prevent the spread of AIDS?

GROUP DISCUSSIONS OF FEMALE STUDENTS

1. Relationship with boyfriends
   (For male students, the focus of this section is on relationship with girlfriends exclusively from prostitutes)
   - 1.1 Is it common for secondary students like you to have boyfriends? Has any of you had a boyfriend? What do you expect from having a relationship at this young age?
   - 1.2 What factors influence students like you to have boyfriends? What prevents you from having the relationship?
   - 1.3 What sort of problems may occur when students have boyfriends?
   - 1.4 Is it common for students to have sex with their boyfriends? Do you know how many of your friends have ever had sex? What are the differences between male and female students in their sexual relations with the opposite sex? Who are their typical partners?

1.5 What leads people your age to have sex? What do they expect from having sexual relations at a young age?

1.6 How many of your school friends live separately from parents? Does this group of friends tend to have boyfriends more than those who still live with their parents?

2. Source of knowledge about sex

2.1 How do you feel about your recent physical developments such as increased breast size and menstruation? What did your parents tell you when you approach puberty like this?

2.2 Do you know what sexual intercourse is? How did you know? What source of information gives you knowledge about sex?

2.3 Is sex education necessary? How is it discussed at school? Do you think the knowledge learned from the classroom is appropriate? How would you like sex education to be improved?

3. Reasons for prostitute patronage

3.1 Why do men have sex with prostitutes?

3.2 Do you think young men your age have sex with prostitutes or not? Who are these men? Do you think you male friends at school have sex with prostitutes?

3.3 Is it possible for men to abstain from sex?

3.4 Are you opposed to prostitute patronage?

4. Response to AIDS

4.1 How AIDS can be transmitted? How can it be prevented?

4.2 Has prostitute patronage changed with AIDS outbreak? What are the consequences of these changes?

4.3 Do you perceive yourself to be at any risk of getting AIDS?

4.4 In the future, would you require your boyfriend to have an HIV test before living together?

4.5 Would you oppose your boyfriend, if you have one in the future, patronising prostitutes?

GROUP DISCUSSIONS OF SINGLE MEN (WAGE EARNERS)

1. Partner selection and sexuality

1.1 How do you select girlfriends?

1.2 How many types of women would you classify in terms of your expected relationship? What do you expect from having relationships with these women?

1.3 How many of you have had girlfriends? What kind of relationships do you expect from these girlfriends?

1.4 Is it difficult to develop relationships with women these days? Why?

1.5 Do you consider female virginity important? Would you marry a woman who has had sexual relations with other men before?

1.6 How do you learn about sex? Is it possible for men to abstain from sex? How about women?

2. Premarital sex
   - 2.1 Is it common to have sex with women who are not prostitutes? Who are these women? Do you expect a long-term relationship with these women? Do you call these women 'girlfriends'?
   - 2.2 What kind of relationships lead to marriage? How would you distinguish between 'casual' and 'committed' relationships?
   - 2.3 What kind of problems may occur when men have sex with girlfriends?
   - 2.4 Do you use condoms with girlfriends? Why do you use condoms with these girlfriends?

3. Prostitute patronage
   - 3.1 Why do men have sex with prostitutes? What are the differences in prostitute patronage between single and married men?
   - 3.2 What factors influenced men to have sex with prostitutes?
   - 3.3 Is lack of a girlfriend considered to be one of the factors leading men to pay for sex?
   - 3.4 Do you think that it is safe to have sex with prostitutes these days? Was it safe before?
   - 3.5 Do men use condoms with prostitutes? How regular is the use? When did men start to use condoms with prostitutes? Do you think some men may avoid using condoms? Why?
   - 3.6 What would stop men from going to brothels?

4. Response to AIDS
   - 4.1 How do people your age respond to the recent outbreak of AIDS? How can HIV transmission be prevented?
   - 4.2 Do you perceive yourself to be at risk of getting AIDS?
   - 4.3 Would you like to have an HIV blood test?

Appendix

C

Case Studies of Prostitutes

Five of 15 prostitutes interviewed in this study are selected for descriptive life history reviews. Some of them were interviewed at their workplaces and others at STD clinics. All prostitutes claim that all customers are required to use condoms; however, some of them may not use the condoms regularly if the clients later become their boyfriends. Background characteristics and the process of becoming prostitutes for selected women are summarised in Tables 1 to 4.

There are several differences between direct and indirect prostitution other than the type of workplace (see section 1.3 in Chapter 1 for categories of prostitution in Thailand). Brothel-based prostitution is a typical form for the direct type. A number of prostitutes are available for selection at the brothels. The cost of sex service ranges from 50 baht (A$2.5) per 30 minutes to 200 baht (A$10) for overnight. The clients do not pay more if they take the prostitutes at the brothels. More payment is required to take the prostitutes out. The average number of clients for direct prostitutes is about five to six a night but can be as high as 20 to 30 men a night during the festival times as reported by three prostitutes interviewed in this study. Brothel-based prostitutes have a weekly or monthly STD check-ups at the government clinics free of charge. A box of free condoms is distributed by the public health staff to motivate them to come for regular check-up. Their routine STD check-up is very crude, however. The examination usually includes per vagina examination performed by nurses to detect visible STD symptoms such as discharge or ulceration in the genital area. Some of them may have been selected for HIV blood test in the past few years.

Masseuses and restaurant-based waitresses are known to offer indirect prostitution. In a well established massage parlour, the number of masseuses can be as high as 1,000 women in a workplace as reported in Bangkok (see Narumon, 1988). The number of masseuses observed in Chiang Mai massage parlours is about 30 to 50 women. The number of restaurant-based prostitutes is up to 20 in some places. The cost of sex service given by masseuses is high. The medical care and the STD check-up are usually given at their workplace by paid medical staff. Some masseuses may seek medical care from the private clinics. They do not go to the government STD clinics since they perceive that the service there is mainly provided for low paid prostitutes only. Information about life history of masseuses and detailed description about their work can be seen from a participant observation study conducted by Narumon (1988). Only three restaurant-based prostitutes were interviewed in this study. They take one client a night and their clients usually wait to take them out after the restaurant closing time. The cost of sex service can be negotiated with a minimum charge. The clients pay them directly; however, they must pay up to 40 per cent of the charge to the restaurant owner on the following day as a service fee. The cost of sex service ranges from 200 baht (A$10) to 800 baht (A$40). The prostitutes usually take their clients to their place for sex, or else the clients need to pay extra for hotel rooms. Some men perceive restaurant-based prostitutes as their girlfriends not prostitutes.

CASE 1 (indirect prostitute)

Background information: Wan is a 37 year-old woman from Chiang Mai. She is the elder daughter among two children in the family. Her parents have no particular occupation and earn no regular income. She and her sister have primary education only. At age 14, she went to Bangkok to look after the children of her aunt who is the youngest sister of her father. She had three to four boyfriends while she was in Bangkok but she did not let them have any physical contact beyond holding hands.

Situation on entering prostitution: With her consent at age 16, her aunt took her to 'penetrate virginity' (*poet borisut*) or to have the first sexual intercourse with a man for money. Her aunt explained to her that the value of women's virginity should not be destroyed by letting boyfriends have sex with them for nothing. With high respect for her aunt, she was convinced and agreed to do it without any objection. The partner of her first sexual intercourse was a Chinese man in his 40s. She does not know how much money her aunt received from her first sexual intercourse but she knows that some money was given to her father. Her aunt gave her a pill to take after the sexual intercourse to prevent pregnancy. She believes that she could repay the debt of gratitude to her aunt and parents by doing this and she has never regretted her decision. She continued living with her aunt for another two years before returning home at age 18.

She returned home to be with her parents until age 20 when she went to Saraburi province to become a disco girl or *sao rum wong*. With her parents' consent, she wanted to take the job to earn money for the family. She was confident that she would not be deceived into prostitution because the contact person for the job was a local woman from her village.

Wan perceives her life as a disco girl as her happiest time: she met many people and did not need to do any housework. There were about 200 women working at the bar where she was. Her income 15 years ago was about 400 baht (A$20) a month plus half of the money that the customers paid for drinks. Her job was to be a dancing and a drinking partner for men. Although some disco girls may earn extra income by going out with men for sex, she never took any clients. Those who do get 50 per cent of the cost of sex service from the bar owner. She had a few men interested in her but had no sexual relations with any of them until she met her husband at age 23. Her husband who is also a local person of Chiang Mai was a singer at the same bar. They began living together after two months of knowing each other. She could not get along with his mother so she later separated from him when their only daughter was five months old. She kept the daughter and continued working as a disco girl until age 30 when she returned home.

Both of her parents died not long after she went home. She has no income and has no savings from her previous work; her sister who works in a Southern province financially supports her and her daughter. She has had a difficult life because she could not find enough money to support the education of her daughter. Her parents' house has been sold to pay off the debt. To earn money, she had tried working as a housemaid for a few years but she found that the job was too demanding. The house owners were never satisfied with her work. She later became a restaurant waitress in the city and started to have sex with men for money only two months before the interview. She earns 60 per cent of the cost of sex service and the rest goes to the shop owner. There are four sex workers with three bedrooms at the restaurant.

Sexual health, condom use and STD prevention: She does not seek a regular check-up at the government STD clinic because she sees herself as not yet a full-time prostitute. She claims to have been infected with syphilis only once when she was living with her husband. She has had sex with only four clients; all except one with condom use (one of the clients has sex with her twice and refused to use a condom in the second episode). She worries that she might get AIDS from this unprotected sex. She usually buys condoms from her workplace (but I identified the condoms which cost her 15 baht (A$. 80) as free condoms distributed by the Ministry of Public Health). She is not aware that the restaurant's owner is taking an advantage by selling free condoms to her and the clients. She experienced a condom break once, and she blames this on poor quality. Two of the four clients asked her to give fellatio but she refused to do. She douches her

vagina with tap water after intercourse. A birth control injection is used to prevent pregnancy.

Current status: Wan's current boyfriend is a regular customer at the restaurant. They have met for two months since she just started working there. She claims that her boyfriend is not aware that she has slept with other men for money. They have had sexual relations four times, all without condom use. She has never demanded money from her boyfriend as she expects to live with him soon. Her only daughter is now 13, and works as a shop assistant after completing primary school.

CASE 2 (indirect prostitute)

Background information: Armee is a 27 year-old member of a hill-tribe minority in Chiang Rai province. She is the fourth daughter among seven children in her family. She has never attended school. At age 17, she married a man from the same hill-tribe and had a son. They separated after four years as she ran away from her husband to live with a non hill-tribe boyfriend in Chiang Mai. Her new boyfriend is an alcoholic who often beats her when he gets drunk. She always feels ashamed about leaving her family to live with this man. She had escaped to live elsewhere before but this boyfriend always got her back for sexual intercourse: she could not resist him even when she had a period. She was under strong pressure from lack of income and was forced to have frequent sexual intercourse during her two years living with him.

Situation on entering prostitution: To earn a living , she became a waitress following a friend's advice: she earns 120 baht (A$6) a day working from 6 pm until 3 am. Her job is to serve food and drinks and to look after the customers. She enjoys the work because it is an easy job and she has a chance to speak in her dialect with some other hill-tribe women who also work there. Although they had lived separately, her previous boyfriend followed her home many times and forced her to have sexual intercourse. She had hardly received money from this boyfriend and had to cover all the expenses by herself. She never sends money to her family in Chiang Rai because of lack of money left over.

After a few months of working, she noticed that several friends at work often go out with the male customers after midnight. They told her that they were going out with their boyfriends. She later realised that her friends go out with these men for sexual services and they earn between 200 and 1,000 baht (A$10-50) a night. Subsequently, she started going out with the customers three years ago (1990). Her first customer was a married man aged 49 who regularly visited the city on business. He used a condom with her which was the first time that she had ever used condoms. She did not understand why this man used the condom with her, and she would have not resisted if he had refused its use since this man looked cleaner than her previous boyfriends. She earned 500 baht from her first sex service and this man became her regular customer.

Sexual health, condom use and STD prevention: She has demanded that all customers use condoms since the end of 1991. She usually provides the condoms but some customers prefer to use theirs. She takes antibiotics every week. She douches her vagina with a commercial solution after every intercourse.

Current situation: She finally terminated with her boyfriend and has started to take many customers several months ago. Some men see her once a week, but they all use condoms. She has been out with the customers almost every night in the past two months. She looks forward to joining her family in Chiang Rai when she has earned enough money to return.

CASE 3 (brothel prostitute)

Background information: Lamai is an 18-year-old woman from a Central province. She is the eighth daughter among ten children in the family. Her father is a wage labourer and her mother is a seller at the market. She went to school at age 10 but left after a year because her parents wanted her to help them earning the living for the family. Her first job at age 11 was dish washing at a restaurant where she worked for four months. Subsequently, her father took her to Bangkok to be with her sisters who had been there for construction work and prostitution. Three of her sisters were prostitutes then, two of them were in Bangkok and one was in Chiang Mai. She earned a living as a construction worker until five years later when her parents were pressured to sell their land to repay a debt. To alleviate their financial hardship, she told her parents that she was willing to be a prostitute like her other sisters.

Situation on entering prostitution: In 1992 at age 17, her parents took her to Chiang Mai to accompany her sister who is a prostitute there. They had looked in vain for a client who would pay a high price to have sex with her, or to penetrate her virginity (*poet borisut*). Failing to find a willing client in Chiang Mai, her parents subsequently took her to Bangkok where a man in his 60s paid her parents 10,000 baht (A$500) to have her first sexual intercourse. With her parents' knowledge, 13 men paid to have sex with her this year: all without condom use because these men believed that she was still a virgin.[1] In the following year, she worked as a restaurant prostitute in Bangkok for several months. Her father took her to accompany a sister in Chiang Mai a few months before the interview. Four of seven daughters from her family currently work as prostitutes, all except her eldest sister send remittances home to support the family. She sends her parents about 3,000-5,000 baht ($A150-250) a month. She has determined that she would not allow her younger sisters who are now in primary school to become prostitutes. Her parents no longer work and are financially dependent on remittances from her and her sisters only. Her brothers could not give much financial support to the family since, as she claims, they all have their own families to look after. Families of her two brothers still live in the same house with her parents. Apart from her parents, two older brothers and two younger sisters, there are a niece and a nephew and two daughters-in-law who lack income and are financially dependent on her earnings. Occasionally, her younger sisters visit her asking for more money for the family.

Sexual health, condom use and STD infection: She takes birth control pills to prevent pregnancy. The only time she was infected with an STD was a few months ago after she moved to Chiang Mai. She was infected with gonorrhoea for a month. She claims that the infection was long because it was resistant to treatment and also she did not stop taking clients during the time she was infected. She thinks that the infection was caused by condom break which she has experienced about five times during her five months working in Chiang Mai. She explains that condom break can occur with three kinds of clients: those with penile pearl or Benz circumcision, those who enjoy forceful intercourse and those with large penises. She notices also that condom break occurs

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1. She uses the term 'open virginity' to describe her sexual intercourse with these 13 men in her first year of prostitution (*poet borisut 13 khrang*). To her, having had the first sexual intercourse does not mean that she has completely lost the value of her virginity. Men still pay a high price of 3,000 to 5,000 baht (A$150-250) to have sexual intercourse with her after her first sexual intercourse. She took only one client at a time in the first year of prostitution. These clients came to see her at the dormitory where she stayed and they went out for sex. The price of subsequent sexual intercourse with 'supposedly' virgin women was addressed in another study (see Narumon, 1988: 116).

when the clients put on the condoms themselves, so she prefers to put the condoms on for them. She claims that while working in Bangkok she never met any men with penile pearls, but has met about six of them during her short time in Chiang Mai. Men with penile pearls are various ages from 18 to 40. It is painful to have sex with these men and condom break may occur but for money she could not refuse this kind of client. She has had sex with two men with Benz circumcision. Although all clients are required to use condoms because of AIDS, she has found that 15 or 16 times her clients attempted to take condoms off during intercourse, and they were forced to put the condoms back. With regular use of condoms, she needs to insert a finger to clean off the lubricants inside her vagina after sexual intercourse with every client.

Current situation: Lamai has been a prostitute for two years. She has never had a boyfriend other than having sex with clients for money. She has eight clients a night on average but the number of clients rises to about 20 a night during festival times.

CASE 4 (brothel prostitute)

Background information: Wong is a 28-year old woman from Chiang Rai province. She is the youngest daughter among three children in the family. Her parents grow plant crops as an occupation. After finishing primary school at age 13, she went to Bangkok to look after her aunt's children for nine months. She came to Chiang Mai afterward to work as a baby-sitter. At age 16, she met her first boyfriend who worked near the place where she worked. They went out a few times but she never allowed her boyfriend beyond holding hands. Her parents forced her to return home at age 17 to marry a man 18 years her senior. Her husband whom she had met only a month before marriage worked as a government officer. Her parents felt that her marriage would be a happy life because her husband had a secure job. She disliked her husband because he is much more older than her. However, she perceives her marriage life in the early years as a happy time. They have two children together. She noticed that her husband's behaviour had changed after seven years of marriage. Besides his usual habit of heavy drinking and gambling, he distanced himself and did not look after the family. She later found that her husband had an affair with a widow from a neighbouring district. To keep her marriage, she ignored her husband's extramarital affair for a year but he did not stop the affair so she asked for a separation at age 23. She keeps the children and returned to live with her parents. She earned no income for living.

Situation on entering prostitution: She was persuaded by a woman in the village to enter prostitution. With lack of stable income, she decided to be a prostitute by own choice at age 24. Her prostitution started at a brothel in the well-known red light district of Chiang Mai (Kamphaeng-din) in 1989. She believes that nobody in her family knows that she has worked as a prostitute. She told her parents that she has worked as a waitress in Chiang Mai. She sends remittances home, about 2,000-3,000 baht (A$100-150) a month.

Sexual health, condom use and STD infection: She is not afraid of getting pregnant because she was sterilised after the birth of the second child at age 24. To prevent an HIV infection, she has demanded that all clients use condoms since 1991. To prevent STDs, she goes for a regular check-up at the government STD clinic. She gets a shot of Kanamycin once a month and takes the antibiotics tablets (called T.C. mycin) once a week. She claims to have had an STD blood test at the government STD clinic every three months (but I am not sure what kind of blood test she regularly has since only syphilis, hepatitis B and HIV can be detected by blood tests). She said she has never had an STD infection. She complains that because of her frequent use of condoms it is

difficult to clean off the lubricants from her vagina. She needs to insert a finger to clean off the lubricants, or else she would develop vaginitis. She claims to have had clients with penile pearls almost every week. This group of men tends to be construction workers or those with low-paid occupations. Penile pearls cause painful intercourse and probably lead to condom break. She believes that some of her clients may have had an injection to increase their penis size as she was told by some clients who have had it done. From her experiences, condom break may occur from forceful sexual intercourse or from sexual intercourse with men with penile pearls. Her concern about condom use is that the condoms dry very quickly if it takes a long time to finish sexual intercourse. The sexual intercourse is painful with lack of lubrication so another condom is needed to lubricate long coitus. She does not want to apply KY jelly not only because she is allergic to it but also because it is too expensive. Some men offered her more money for fellatio but she has never done it because the practice is very offensive to her.

Current situation: She met her current boyfriend more than a year ago while she worked at another brothel. They have moved to be together at this brothel where he works as a brothel keeper. She has never used condoms with her boyfriend because she is confident that her boyfriend has sex with her only, and she always uses condoms with other men. She has about eight clients a night on average. The highest number of clients she has had is during New Year and Buddhist festivals (*khaw-, ok-phansa*) in which she has about 20 men a night.

CASE 5 (brothel prostitute)

Background information: Nong is a 21 year-old woman from a North-eastern province. Her parents are farmers. She is the oldest child among three children. She completed primary education at age 12. After helping her parents with farming for two years, she went to live with an uncle in Bangkok at age 14 to work as a factory worker. Her uncle expected her to help him with house work and to look after his children so she did not have a chance to go out with friends. The first time she went out with friends was at age 17, three years after coming to Bangkok. She asked her uncle for permission to go out with female friends at night. They went to a discotheque and came home late which very much upset her uncle. He told her not to go out again, but she did in the following week. She met a boyfriend the second time. All of her friends spent time with their boyfriends when they went out together so she felt like having a boyfriend like others. A week after meeting this boyfriend, she was taken to a hotel and lost her virginity to him. Her uncle was very upset so she left Bangkok and returned home to see her parents the following day. She came back to Bangkok in a month to be with her boyfriend but found that he already had a wife. She went back to stay with her uncle and got another job in a factory. She resigned from the job after eight months because she could not get along with her supervisor.

Situation on entering prostitution: Nong says that she felt helpless when she was unemployed then. She did not have anywhere to go and did not feel like returning to her uncle or her family. During this time of confusion, she met a middle aged couple who said her that they could find her a good job. They took her to a seaport province and later sold her to a brothel. The brothel owner claimed that she owed him 2,000 baht (A$100) since the couple who took her there had been advanced the money from her account. She was forced into prostitution and was beaten by the brothel keeper when she refused to have sex with clients. Her first client was a middle aged Chinese man who paid 5,000 baht (A$250) to have sex with her. Because of her debt, she received no income in the first three months of her prostitution, and received half of the sex service

cost thereafter. She had about six to seven clients a night on average with the highest number of 23 clients a night. Many of her clients were fishermen or sea workers. After working in the seaport province for three years, she decided to move to Chiang Mai following many of her friends who come from the Upper-north region. She has never told her parents that she works as a prostitute. She sends about 1,000 baht (A$50) home every month.

Sexual health, condom use and STD prevention: She was pregnant once during her early prostitution. She was not told by anyone to prevent pregnancy at that time. She had an abortion when she was three months pregnant which cost her 3,700 baht (A$170). She now takes birth control pills to prevent pregnancy. To prevent HIV infection, she prefers to put two condoms on clients in case of condom break. However, it was difficult to put condoms on men with large penises. She often changes to another condom for clients during coitus because the lubricant dries out quickly. She examines the client's genitals every time to detect any sign of infection before putting on condoms for them. She forces the clients to clean their genitals before sexual intercourse if she feels that they are dirty. She was infected with an STD five or six times while working in the seaport province. She blames condom break for these infections. To prevent STD infection, she goes for an STD check-up at the government clinic every week and has a blood test every three months. She often takes an antibiotic (called Lyfardin) which is a diuretic drug to prevent the infection. This drug causes reddish urine and she believes that the STD germs have been flushed out of her body through the darkened urine. She has clients with Benz circumcision every month and has men with penile pearls almost every day since she came to Chiang Mai. These men tend to be construction workers. She refuses to take any clients who implant several pearls in the penis because they make intercourse painful.

Current status: She has three to four clients a night and the highest number is 16 clients during the winter festival. She has no boyfriend but would like to return home to have a family when she earns enough money.

Table 1 Background characteristics of selected masseuses (indirect prostitutes)

Name	Age	Education	Place of origin	Parents' occupation	Situation before entering prostitution			Age at first intercourse	Length of time working as a prostitute in years
					Occupation or status	Marital status	Relationship with family members		
Malai	45	Grade 2	Chacheongsao	Farmer	Housewife	Divorced*	Neglected by husband	24	21
Dang	30	Grade 10	Chiang Mai	Wage earner	Housewife	Divorced*	Abusive husband	20	10
Dara	29	Grade 4	Khon Kaen	Wage earner	Hair dresser assistant	Single	Abusive parents	19	10
Malee	21	Grade 2	Chantaburi	Agriculturist	Waitress	Single	Abusive parents	16	5
Toi	22	Grade 4	Payao	Farmer	Farmer	Single	Ordinary	17	5
Tim	24	No schooling	Chiang Rai	Agriculturist	Housewife	Divorced*	Father has a new wife	20	4
Jan	22	Grade 9	Nakhonsawan	Government official	Student	Single	Restrictive parents because she was a drug addict	18	4
Jim	22	Grade 9	Prae	Government official	Student	Single	Rejected by parents because she has sexual relations with boyfriend	16	6

* Refers to living separately because none registered their marriage

SOURCE Narumon, Suliman 1988. *Nangngam tukrachok* (Pretty women in the glass window). Bangkok: Kledthai. (in Thai), p. 190.

Table 2 The process of becoming masseuses (indirect prostitutes)

Malai Aged 45	Age	1-17	18-23	24	24-26	27-30	31	32-33	33-34	34-35	36-37	38-39	39	40-42	43-45
	Situation	Farmer	Married with 4 children	Divorced, becomes a wage earner	Becomes a masseuse	Lives with a man wh supports her for a dress-making course	Separates, opens a tailor shop	Returns to be a masseuse	Supports by another man, becomes a casual wif	Works as a bus driver	Masseuse	Masseuse	Bar girl	Masseuse	Masseuse
	Place	Chacheon gsao	Bangkok										Macao	Bangkok	
	Duration	-	5 years	7 months	2 years	4 years	1 year	2 years	1 year	2 years	> 1 year	> 1 year	5 months	3 years	3 years

Dang age 30	Age	18	19	19-20	20-21	21-22	22-24	25	26	28					28-30
	Situation	Married with a child	Divorced, lives with a sister	Returns home	Becomes a masseuse	Masseuse	Masseuse	Overseas prostitute, works wit agency	Overseas prostitute, seek clients by self	Prostitute	Returns to Thailand	Prostitute	Returns to Thailand	Prostitute, seeks client herself from hotels	Masseuse
	Place	Chiangma	Bangkok	Chiangma	Chonburi	Chiangma	Bangkok	Malaysia	Singapore	Macao	Bangkok	Germany	Bangkok		
	Duration	-	8 months	4 months	1 year	1 year	> 2 years	1 year	2 years	4 months	1 month	3 months	1 month	1 month	3 years

Dara age 29	Age	15	16-17	17-19	19	20	21-22	23-24	25-27	27-29
	Situation	Helps parents with work	Works at a beauty shop	Second wife of a man	Separates because she has an affair with another man	Works as a masseuse	Supports by another man	Has a child	Overseas bar girl	Masseuse
	Place	Khon Kaen	Bangkok						Japan	Bangkok
	Duration	-	1 year	2 years	1 month	2 years	2 years	2 years	2 years	3 years

Malee age 21	Age	10	11-12	12-13	13-14	15-16	16	16-18	18-19	19-21								
	Situation	Lives with parents	House maid	Street vendor	Street vendor	Restaurant waitress	Pregnant with a boyfriend, has an abortion	Waitress but also sleeps with men for money, seek clients from hotels	Nude model	Masseuse	Masseuse	Masseuse						
	Place	Chantaburi							Bangkok	Bangkok	Bangkok	Bangkok						
	Duration	-	2 years	6 months	2 months	> 2 years	> 2 years	> 2 years	> 1 year	10 months	4 months	5 months						

Toi age 22	Age	1-17	17-18	18	18-19				19-20	20		21-22						
	Situation	Lives with parents	Entering call girl as a virgin	Returns home	Hotel-based prostitute	Returns home	Masseus	Father is ill, returns home	Masseus	Hotel-based prostitute	Kept wif of a man	Masseus	Masseus	Returns home	Masseus	Returns home	Masseus	
	Place	Payao	Bangkok	Payao	Malaysia	Payao	Bangkok	Payao	Hatyai	Malaysia		Hatyai	Bangkok	Payao	Bangkok	Bangkok	Hatyai	
	Duration	-	7 months	2 months	3 months	2 months	2 months	1 month	1 year	2 months	1 month	2 months	7 months	10 days	> 1 month	-	2 months	

Tim age 24	Age	15-19	20	20-21					22-23						24			
	Situation	Married with two children	Divorced	Hotel-based prostitute	Masseus	Returns home	Hotel-based prostitute	Masseuse	Returns home	Masseuse	Returns home	Masseuse	Masseuse	Returns home	Prostitute	Masseuse		
	Place	Chiangrai		Malaysia	Hatyai	Chiangra	Malaysia	Hatyai	Chiangra	Bangkok	Chiangai	Hatyai	Bangkok	Chiangra	Bangkok	Hatyai		
	Duration	-	10 months	3 months	3 months	> 1 month	3 months	3 months	1 month	7 months	> 1 month	4 months	2 months	10 days	3 months	3 months		

Jan age 22	Age	16	17-18	18-20					20-22
	Situation	Stops schooling at grade 9, dislikes school, prefers to go out with friends	Drug-addict	Runs away from home	Persuaded by an acquaintance to enter prostitution	Prostitute and call girl	Masseuse	Supports by a man as a kept wife	Separates, return to be a masseuse
	Place	Nakhonsawan			Chiang Mai	Bangkok			
	Duration	1 year	> 1 year	1 week	5 months	4 months	9 months	2 months	> 2 years

Jim age 22	Age	15	16	16-17	17-18	18-19		19-22
	Situation	Has sex with a boyfriend at grade 9, rejected by parents, runs-away from home	Has an abortion	Masseuse	Returns home because father dies	Masseuse	Call girl	Masseuse
	Place	Prae		Bangkok	Prae	Bangkok		
	Duration	16 years		1+ year	1+ year	1+ year	4-5 months	3 years

SOURCE Narumon, Suliman 1988 *Nanghgam tukrachok* (Pretty women in glass window). Bangkok: Kledthai. (in Thai), pp. 163-4.

Table 3 Background characteristics of selected prostitutes interviewed in this study

Case	Age	Education	Place of origin	Parents' occupation	Situation before entering prostitution			Age at first intercourse	Length of time working as a prostitute in years
					Occupation or status	Marital status	Relationship with family members		
Dao	25	No schooling	Chiang Rai	No occupation	Housewife	Divorced*	Forced into marriage	17	1+
Ew	19	Grade 6	Chiang Rai	Farmer	No occupation	Single (virgin)	Ordinary	17	2
Duan	29	Grade 2	Chiang Mai	Agriculturist	Farmer	Divorced*	Abusive husband	17	2+
Lamai	18	Grade 1	Udornthani	Wage labourer	Construction work	Single (virgin)	Ordinary, sisters work as prostitutes	17	1+
Yai	33	Grade 3	Chiang Rai	Farmer	Farmer	Single with sexual experience	Ordinary	18	6
Toi	33	Grade 4	Chiang Mai	Farmer	Housewife	Divorced*	Husband is a gambler	28	1+
Nang	45	Grade 2	Chiang Mai	Agriculturist	Housewife	Divorced*	Abusive husband	22	5
Wan	37	Grade 4	Chiang Mai	No occupation	Disco girl	Single (virgin)	Ordinary	16	1
Jai	25	Grade 3	Payao	Agriculturist	Housewife	Divorced*	Ordinary	17	2
Yao	25	No schooling	Chiang Rai	Agriculturist	Wage earner	Single with sexual experience	Ordinary	15	4
Eng	32	Grade 9	Pitsanulok	Barber	Housewife	Divorced	Husband has extramarital affair	19	4
Wong	28	Grade 4	Chiang Rai	Farmer	Housewife	Divorced*	Forced into marriage	17	4+
Armee	27	No schooling	Chiang Rai	Grow cash crops	No occupation	Divorced*	Runs away from husband	17	3+
Som	23	Grade 4	Chiang Mai	Agriculturist	Housemaid	Single (virgin)	Ordinary	13	5
Nong	21	Grade 6	Srisaket	Farmer	Factory worker	Single with sexual experience	Ordinary	17	5

* Refers to living separately because none registered their marriage

Table 4 Process of becoming prostitutes of selected women as interviewed in this study

Dao age 25	Age	1-16	17	19	22	23	24
	Situation	7th daughter of a hill-tribe family with 9 children. Never attends school	Forced by parents into marriage with a man from the same hill-tribe	Divorced because husband has an affair with other woman. Returns to live with parents	Refuses 2nd marriage. Runs away from home following two friends to work as a prostitute	Returns home from homesickness, tells parents that she works as a prostitute	Returns to prostitution
	Place	Chiang Rai			Bangkok	Chiang Rai	Chiang Mai
	Duration	16 years	2 years	3 years	6 months	6 months	1 year

Ew age 19	Age	1-15	16	17	17	18	19
	Situation	2nd daughter among 2 children. Helps parents with farming after primary school	Parents need money to build a house, asks parents to follow her aunt to be a prostitute, parents refuse	Runs away with 20 friends following her aunt to be a prostitute by her choice, has 1st sex as a virgin, works as a cafe-prostitute	Quits prostitution to live with a boyfriend who is her regular client, has one daughter	Separates from husband, returns home to be with parents	Returns to prostitution following four friends who all work as prostitutes
	Place	Chiang Rai		Phuket		Chiang Rai	Chiang Mai
	Duration	16 years		7 months	1+ year	1 + year	1+ year

Duan age 29	Age	1-16	17	18	20	23	23	24
	Situation	2nd daughter among four children. Quits school to help parents with farming after grade 2	Has 1st sexual intercourse with a boyfriend without parents' knowledge	Lives with a boyfriend who becomes her husband, separates because husband is abusive	Returns to live with parents.	Becomes a prostitute following friend's advice with parents' consent	Meets 2nd husband who is her regular client, quits prostitution to live with husband	Separates because husband is an alcoholic, returns to prostitution
	Place	Chiang Mai						
	Duration	16 years	1 years	2 years	3 years	4 months	1+ year	2 years

Lamai age 18	Age	1-10	11	17	17	17	18
	Situation	8th daughter among 10 children. Parents have no regular income. A few sisters work as prostitutes.	Goes to Bangkok after grade 1 to be with sisters, works as construction worker	Parents seek a client to penetrate her virginity but fail to get a willing client	Parents find a client for her first sexual intercourse, has sex with 13 men for money	Becomes a restaurant prostitute	Father takes her to accompany an elder sister who is also a prostitute
	Place	Udornthanee	Bangkok	Chiang Mai	Bangkok		Chiang Mai
	Duration	10 years	4-5 years	2 months	4-5 months	4-5 months	5 months

Yai age 33	Age	1-17	18	18	22	28	29-32	33
	Situation	1st daughter among six children. Quits school at grade 3, helps parents with farming	Has 1st sexual intercourse with a boyfriend without parents' knowledge	Runs away from home together with friends to work as prostitutes	Meets a husband who is her regular client, stops prostitution, helps husband with farming, has one son	Separates because husband has sexual affair with many women	Takes several jobs as wage earner	Returns to prostitution
	Place	Chiang Rai		Chiang Mai				
	Duration	17 years		5 years	5 years		2-3 years	5 months

Toi age 33	Age	1-18	19-20	21-27	28	31	32	32
	Situation	2nd daughter among six children. Helps parents with farming after grade	Has 1st boyfriend but never has a sexual engagement	Works as factory worker	Marries a man from the same village, has one son	Separates because husband is a gambler. Husband has 2nd marriage	Takes son home to live with parents, earns no income	Becomes a prostitute to earn living
	Place	Chiang Mai						
	Duration	18 years			3 years		2-3 months	1+ year

Som, age 23	Age	1-10	11	12	13	13	13-21	22
	Situation	6th daughter among 7 children of a farmer family	Finishes grade 4, earns money as a shop assistant	Returns home to help parents with farming	Goes to the city with a neighbour who is a prostitute to work as a maid at the brothel	Encouraged by the brothel owner to tak the first client as a young virgin	Works as a prostitut in a number of brothels with parents ' knowledge	Returns home to be baby-sitter for her sister but returns to prostitution again
	Place	Chiang Mai						
	Duration	10 years	1 year	6- 7 months	2-3 months		7-8 years	1+ year

Nong, aged 21	Age	1-11	12	14	17	17	17	20
	Situation	Eldest daughter among three children.	Completes grade 6, helps parents with farming	Gets a job as a factory worker	Has 1st sexual intercourse with a boyfriend, boyfriend refuses to continue relationship	Gets another job as a factory worker	Deceived into prostitution by a middle aged couple	Moves to brothels in Chiang Mai following friends
	Place	Srisaket		Bangkok			Samutprakarn	Chiang Mai
	Duration	11 years	2-3 years	3 years		8 months	2-3 years	1+ year

Wong, aged 28	Age	1-12	13	14-16	17-23	24	24	27
	Situation	Youngest daughter among three children	Helps an aunt looking after her children	Works as a baby sitter, has 1st boyfriend at age 16, has no sexual relations	Returns home for an arranged marriage with a man 18 years her senior, has two children	Separates from husband because he has an affair with another woman, takes children to live with parents	Works as a prostitute by her choice, tells parents that she works as a waitress	Lives with a boyfriend who is a brothel keeper, continues prostitution
	Place	Chiang Rai	Bangkok	Chiang Mai	Chiang Rai		Chiang Mai	
	Duration	12 years	9 months	3 years	7 years	2-3 months	3 years	1+ year

Armee, aged 27	Age	1-16	17-21	22-23	24-26	25-27
	Situation	A hill-tribe minority, 4 th daughter among 7 children	Marries to a hill-tribe husband, has one son	Runs away to live with a non hill-tribe boyfriend, boyfriend is abusive	Lives separately with boyfriend, works as a restaurant waitress	Have sex with men for money, plans to return home after earning enough saving
	Place	Chiang Rai		Chiang Mai		
	Duration	16 years	4+ years	2 years	2 years	3+ years

Wan, aged 37	Age	1-13	14-15	16	18-19	20-30	31-36	37
	Situation	1st daughter among two children, parents have no stable occupation	Live with an aunt to look after her children	Has the first sexual intercourse with men for money following her aunt's suggestion	Returns to live with parents, has no income	Works as a disco girl, meets husband at age 23, separates after a year, has a daughter	Returns to Chiang Mai, parents have died, sells house, earns living as a housemaid	Becomes a restaurant prostitute, meets a boyfriend
	Place	Chiang Mai	Bangkok		Chiang Mai	Saraburi	Chiang Mai	
	Duration	13 years	4 years		2 years	10 years	5 years	< 1 year

APPENDIX

D

Life Histories of Men with AIDS

A number of people with AIDS and HIV infection were approached throughout the period of data collection. Some of them were contacted for in-depth interviews and some were reported as survey respondents.

CASE 1 (survey respondent)

Kam is a single man aged 19 years who is the only child in the family. He has always lived in the village with his parents even though he started to study at a commerce college in the city two years before falling ill. His village is not a typical rural village as it is quite modern and is located only ten kilometres from the city. Transport is convenient as people can travel to the city by motorcycles or public buses which run every hour. He often goes to college by motorcycle and occasionally stays overnight with friends in the city.

He experienced the first sexual intercourse with a prostitute at age 17 when he was in the first year of commerce college. He claims to have had sexual relations with about 15 prostitutes since then. He did not use condoms regularly but his last sex with a brothel-base prostitute nine months ago was with a condom. The cost of his last commercial sex was 100 baht (A$5). He protected himself from STD infections by urinating and cleaning the penis with hydrogen peroxide after having sex with prostitutes; however, he was twice infected with STDs. Whenever found or suspected to be STD infected, he treated himself by taking drugs bought from the drugstores.

A year before having sexual experience, he had a girlfriend for the first time but he did not attempt any sexual relations with her. He claims to have had sexual relations with six women who were not prostitutes in the last two years. One of them was a friend from college. His last sex was with this woman five months ago. He used condoms with her every time to prevent pregnancy. He believes that this woman probably has had sex with other men before, or else she would not have had sex with him easily. He did not want to prolong their relationship since he prefers to marry a virgin.

Despite the rumours in the village that he has AIDS, he is not sure about his condition and would like to go for an HIV blood test. He believes that he has been ill with asthma, muscle ache and lung disease for several months. The doctors did not inform him about his illness even though he went to two hospitals. He is too weak to continue college and has to remain home under the care of his mother. His condition at the time of the interview was poor. Despite his willingness to be interviewed, he appears to be very thin and weak. When his mother was initially approached as the house was selected for the interview, she denied that her son was at home. However, her son heard the explanation by the interviewer and he told his mother that he would like to be interviewed. It was found on the second visit to the village a few months later that he had died with a confirmed diagnosis of AIDS. Heterosexual intercourse with multiple partners was the mode of HIV transmission in his case as he was known to have no history of drug use.

CASE 2 (survey respondent)

Mai is a single man aged 33 years who comes from a large family with seven children. His mother died many years ago and he lived with his elderly father. Mai has four years of schooling. Construction labour is his known occupation and it gives him a monthly income of about 3,500 baht (A$200). He has always lived in the village: the only time

that he lived away was when he worked in a nearby province for a year as a construction worker.

Mai claims that he has very few girlfriends and he has had sexual intercourse with only one of them at age 20. They knew each other for more than two years before having intercourse; however, they did not live together. He believes that this woman was not a virgin and he prefers to marry a woman who has never passed through the hands of other men. He has no girlfriend in recent years and he perceives that he may be too old to form a relationship with a woman.

His first sexual experience was with a prostitute at age 16. It was common for him and his friends to pay for sex starting at early ages. He claims to have had sex with about 200 prostitutes altogether. The last time that he paid for sex was one year and three months ago; cost of the last commercial sex with a restaurant waitress was 500 baht (A$7). Brothels are his usual place for commercial sex but he enjoys going to places like karaoke clubs or massage parlours which cost more when he earns extra money. For a change of sensation, he asked a friend to implant a few beads in his penis several years ago. The material used for making beads was taken from the bottom of a stimulant drink bottle. About three of his friends also had *fang-muk* implanted like his. He had experienced five STD infections including *fi mamuang* (Lymphogranuloma venerum), *dok kahlam* (Condyloma accuminata) and *hnong-nai* (Chancroid). The STD infections occurred although he frequently takes Choramphenicol which is an antibiotic drug for prevention, and also he urinates after sexual intercourse to flush off the STD germ left in the urethra. He has never seen a doctor for STD treatments as he treats himself by taking antibiotics.

He stopped prostitute patronage over a year ago after finding ulcers around the penis. He went for an examination and was informed by a hospital staff that he is HIV infected. Yet, he believed that he had only a 50 per cent chance of developing AIDS and 90 per cent chance of having an HIV infection. He has taken herbal medicine regularly (which he believes could treat his illness) but this medicine causes epilepsy which left him unconscious for half an hour after taking it. Despite his frail appearance, he appears to be in good spirits living with his father. He does not hide himself from others regardless of his AIDS symptoms. His appearance with AIDS gains much sympathy by others.

CASE 3 (survey respondent)

Tong is a widower aged 43 years. He has five siblings but only he lives with his mother. He worked as a construction worker for many years but became unemployed after falling ill over a year ago. His younger sister became the breadwinner and gave financial support to him and mother.

Tong preferred to isolate himself in a room since he developed the AIDS-like symptoms. He knew that many people in the village said that he has AIDS but he was not sure that he was HIV infected. He said he became ill over a year ago and he went for the HIV blood tests three times. The result of the first two tests was negative; however, he did not return for the result of the third test. Because of the two negative HIV results, he rather believed that his AIDS-like symptoms were caused by his frequent exposure to fertiliser without any protection. He first developed a rash covering the body over two years ago and he started to lose weight in the last four months. He claimed that his symptoms were only AIDS-like and he did not want anyone, even his friends, to visit because all of them thought that he had AIDS. He wanted no sympathy from people

about his illness. People in his village are familiar with people with AIDS because many men in this district had died from AIDS recently. He was claimed by others to be one of the two men with AIDS in the village. The village next to his is a known source for drug dealing: at least four people in his village were known to be drug addicts.

Tong's first sexual experience was with a girlfriend at age 21. He knew this woman for five years before having sexual intercourse, but he did not live with this woman. His wife was the second and the last non-prostitute woman with whom he had sexual intercourse. His wife asked for a divorce only a year after their marriage when he was 29. His only daughter stays with his wife. He was very upset about the divorce and described himself as becoming promiscuous by frequent prostitute patronage since then. He claims to have had sex with about 30 prostitutes after the divorce. The last time he had sex with prostitutes was five years ago (1988). He has never used condoms with any women. He took Pencetin (antibiotic drug) before or after having sex with prostitutes but was three times STD infected. He believes that he had a low chance of being HIV infected. Although he might be HIV infected from frequenting prostitutes, he claims it was unlikely that he would be HIV infected since his last sex with women was five years ago. Neither has he ever used drug injection. At the time of the interview, Tong appears to be very thin with spots like Kaposi's sarcoma covering his body. He also has chronic diarrhoea.

CASE 4 (in-depth interview case)

Boonmee is a married man aged 33 who is in hospital for treatment of full-blown AIDS. His wife joined him at the time of the interview. They both openly admitted Boonmee's condition and were willing to discuss his life story.

Boonmee first had sex at age 16 with a prostitute when he was in grade 9. He was enlisted for two years and later pursued a career in the army. He frequented prostitutes about twice a week for a few years in the early 1980s during the time that he was surrounded by a large group of male friends. They often went out together for social drinks and would end up at brothels. He went to brothels alone when feeling lonely many times. It was common for him to get an STD for which he usually treated himself with a few injections of Kanamycin. Besides prostitutes, he had several non-prostitute women who were sexually engaged with him without any commitment.

He married this wife at age 30 and they had one daughter aged two years. It was the second marriage for his wife who has a daughter aged 13 from her first marriage. They knew each other for two years and never had sexual relations before marriage. Boonmee moved into his wife's family after marriage. His wife said she knew that her husband occasionally went to brothels after marriage but she had never intervened or tried to stop him as she perceived that it was men's common behaviour.

Boonmee said that he had donated blood in 1983 but the doctor told him that his blood was contaminated with fungal infection and requested him not to donate blood. He was not worried about the result then since AIDS has not emerged yet at that time. In 1991, he suspected that he probably had malaria as he had chronic high fever. Several blood tests for malaria were negative so he decided to have an HIV blood test in early 1992 and was found to be positive. He did not feel much upset then because he felt that he was still healthy without any symptoms of AIDS. His wife also knew about the result of the blood test. He has stopped prostitute patronage since then but has had unprotected sex with his wife every month. He has never used condoms as he feels that it is

unnatural. He is still doubtful how long he has been infected with HIV. He claims that the result of his wife's blood test during the time that she was pregnant in late 1991 was normal. His wife has had an HIV blood test recently but the result is not known yet.

Boonmee is a heavy smoker who stopped smoking not long ago. He smoked marijuana a few times and injected opium with a shared needle once in 1983. He and his wife are well aware of his deteriorating condition with AIDS and her chance of contracting HIV.

CASE 5 (in-depth interview case)

Poll is a single male aged 24 with a diagnosis of full-blown AIDS. He is the youngest son in the family, with one older sister. He claims that he misbehaved after grade 8. During that time, his sister got pregnant to her high school teacher which upset his father very much. His father hoped that his children would be highly educated but his sister destroyed his expectation by having a family with her teacher at young age. With disappointment, his father left the family to be a carpenter in Malaysia. Poll had started to go out with friends a lot and had his first sexual experience with a prostitute at age 15. He left school at grade 9 and went to Bangkok for construction work with friends in the following year. He has frequented many prostitutes since then.

Like several young men from his village, Poll later spent five years working as a fisherman in Chonburi province. The job gives better pay than his previous construction work. However, he was addicted to heroin after a year of taking the job. He claims that heroin injection is a well-known behaviour among fishermen because it makes them feel energetic. Almost everyone in the fishing vessels injects heroin to keep them off-shore for several days. Stimulant drugs like amphetamine are not as effective to them as injecting heroin. Although most fishermen enjoy prostitute patronage, the visits become less often when they are heroin addicted. Poll injected heroin twice a day which cost him 50 baht (A$2.5) per injection. Sharing needles is unavoidable among friends in the fishing vessels. The syringe and needle are only rinsed with tap water before reusing.

In 1991, he was sentenced to prison for heroin injection for a year. He received drug treatment inside the prison and has abstained from using heroin since then. Poll claims that some prisoners have sex with other men even though they are not homosexual. Chonburi is a province known to have many bar girls and transvestites. When caught by policemen, the transvestite prostitutes are kept in the same prison and are raped by other men. Heroin or opium injection with shared needles is common in prison. It is also a common daily scene to see prisoners queue up for tattoos, circumcisions and penile pearl implants.[1] A needle used for cloth sewing is used for tattooing inside the prison. Sharing sharp instruments like needles or razor blades is unavoidable because they are scarce.

After release from prison, Pol went back to be with his mother for a year. He later voluntarily enlisted in the army in Chiang Mai in 1991 at age 22. He wanted to be in the army because he did not want to work yet. The army recruits are informed about the AIDS outbreak many times. He did not use condoms with prostitutes in the early years but started to use them some times in the last two years because the prostitutes demand the use. In mid 1993, he developed chronic fever, diarrhoea and weight loss: he

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1. The number of male prisoners in Thailand is between 50,000-60,000 a year from 1988 to 1990. The admission or discharge of male prisoners during this period was around 130,000 a year (National Statistical Office, 1992: Table 86).

suspected that he probably had AIDS. The result of a blood test confirmed that he is HIV-infected. He is worried that his friends and other people may reject him if they know that he has AIDS so he tells them that he has ill with TB. Nobody at home knows that he has AIDS. He separates himself from others while eating to prevent others from getting AIDS from him. Poll will be discharged from military service soon. With support from his mother, he hopes to have a chicken farm for living at home. He looks thin but healthy despite the fact that he is in the third stage of full-blown AIDS.

CASE 6 (in-depth interview case)

Tom is a single man aged 20 who is in hospital for treatment for drug inhaling at the time of the interview. He is a healthy co-operative young man who is pleased to talk about his life story. He seeks drug treatment because he wants to terminate the drug addiction. His HIV status was not known when approached for the interview.

Tom is the only child in the family. His father died at the age of 21 and Tom lived with his mother until completing grade 9. He went for higher education in a Polytechnic college in Nakhonsawan which is a province close to the central region. He lived with the family of an aunt but later moved out to a dormitory with friends because of frequent conflicts with his aunt. He had become very socialised and was involved in heavy smoking, drinking, inhaling drugs, fighting and patronising women. He sees himself as too far gone in vice by this age already. Some of his friends forced women for pack rape but he said he never joined them. He has frequented prostitutes and has sexual relations with several women, some of whom lived with him briefly.

He resigned from the college without informing his mother and worked as a waiter for a living. His mother soon found out and took him back to Chiang Mai. He worked as a waiter in Chiang Mai and was sexually involved with a woman at the same restaurant. They lived together for three months but his girlfriend was forced by her parents to marry another man. He was upset about this separation and became severely addicted to inhaling drugs. During that time, he was persuaded by a friend to work as a male prostitute at a gay bar. He claims that the customers of gay bars are Thai and Western men, a few women also pay men for sex. He dislikes having sex with men so he often goes to brothels for pleasure with women. He was later in love with a prostitute whom he persuaded to leave the job to live with him. They both took other jobs at restaurants and lived with his mother. He visited his girlfriend's parents in Chiang Rai and was asked to pay them 500 baht ($25) for *sia phii* or payment for spirits feast (see Chapter 5). The money is used to buy a pig head for the feasting in the spiritual cult of his girlfriend.

His girlfriend returned to prostitution following her friend's persuasion, so they later separated. He met another woman who is a masseuse, and moved to live with her in Nakhonrajasrima province. At age 18, he worked briefly as a male prostitute three times in this province to earn a living whenever he broke up with girlfriends. All male prostitutes are required to have a weekly STD check-up at the government clinics, and he was found to be HIV infected in 1991 so he was sent back to Chiang Mai for observation (see Chapter 2 for the policy of HIV prevention in the early years). He returned to prostitution again in Chiang Mai; however, he tended to use condoms after knowing that he has HIV. A large quantity of lubricant is required when using condoms for anal sex. Baby lotion, vaseline or saliva is often used to lubricate coitus because he cannot afford to buy KY jelly is too expensive.

Tom has continued his sexual relations with many prostitutes despite his knowledge that HIV can be transmitted by sexual intercourse. Condom use with prostitutes is rare because he dislikes the use and some prostitutes have trust on him. Neither does he use condoms with some of his non-prostitute women. He protects them from getting HIV by using *coitus interruptus*. He has had sexual intercourse with five non-prostitute women since he has been infected with HIV, two without condom use. He claims that he has had sex with more than 50 female prostitutes, 30 men and six girlfriends, three of whom are prostitutes. Another four or five women were sexually engaged with him without commitment. He has been infected with an STD only once and he treated himself. He often drinks a lot of soda water before or after sexual intercourse to flush out the STD germ through urination.

After receiving the drug treatment, Tom worked as a waiter in several restaurants in Chiang Mai. He was prevented from taking a job in a few places where the workers need to be AIDS free. The HIV blood test is required in many service jobs. In early 1994, he developed chronic diarrhoea as an early sign of full-blown AIDS. Yet he lived with another girlfriend and had sexually engaged with her without condom use. He could not earn any money and was forced to borrow money from acquaintance for food. He later voluntarily enlisted in the army in April 1994 at age 21. He recognized that the benefits of being an army conscript include at least free medical care when falling ill. He was admitted to an army hospital for AIDS treatment a few months after enlisting.

Appendix

E

Life histories of selected men and women

Men's life stories

CASE 1

Sak is a single university student aged 24 years. He is the youngest son among four children. His parents own a small grocery shop near the red light district in Chiang Mai city. He had first sexual intercourse at age 16 when he was in grade 9. He went to a brothel with more than 10 friends from school who were all drunk for a celebration at that time. He said that male students usually go for group drinking following by prostitute patronage to celebrate the completion of their study at grade 9. Thai students must decide about their continuing education and their career paths at this grade: some students might terminate education for employment, others might continue vocational or commerce college for diploma degrees, and some might continue onto high school for later university education.

He went to brothels with friends as a school student several times. The cost of sex service that he usually paid was 200 baht (A$10) in 1985. He was able to pay for a more expensive sex service at the massage parlour or a karaoke club every few months when earning money from his part-time jobs. However, he has stopped paying for sex in the past few years after knowing some students who are willing to have sex with him without commitment. These women who are mostly vocational, college or university students support their own education and expenses by having sex with selected men for money. He believes that very few women in his generation could maintain their virginity until marriage. However, young people no longer perceive that women's virginity is an important factor to form a stable relationship. He does not mind if his girlfriend has had sex with other men before marriage. Many of his friends at the university are sexually engaged with their girlfriends starting from the first year of their university life. He believes that women are more willing to have premarital sex with boyfriends these days to obligate their marriage. In contrast, men do not perceive premarital sex to be a condition to marriage. They believe that these women probably have had sex with other men as well. Very few students pay for sex with prostitutes now because they are afraid of getting AIDS. Additionally, there is no need for them to pay for sex with prostitutes any more since an increasing number of women are willing to be sexually engaged with men more than before.

Sak says a female student who has sex with men for money is a 'kept partner', not a second wife. This kind of partner is similar to a prostitute because men pay to have sex with these women without long term financial commitment. The kept partners can be contacted by their agents such as transvestites or middle-aged women who get 10 per cent of the charge from their customers. However, these highly educated prostitutes have a strong bargaining power; they may refuse to take any men. Sak is not afraid of getting an STD from sexual intercourse with several women because he uses condoms with all of them. He claims to have had sex with 20 non-prostitute women and has had sex with prostitutes more than 50 times.

CASE 2

Noi is a 30-year old man who works as a government officer. He is the elder son of two children in the family. He had his first sexual experience with a prostitute at age 15 when he was in grade 10. He went to a brothel with several friends for a celebration. His first sexual contact with non-prostitute women was with a girl aged 16 from a nearby village. He had sexual contact with her without his parents' knowledge, but the girl's parents forced him to take responsibility. He later separated from this girlfriend when he went

for higher education in the city. He was married at age 20 to a 13 year-school-girl. He was forced into marriage by his girlfriend's parents. They separated after two years of marriage. He claims that his marriage failed because his wife was too young and she was highly influenced by her parents.

He claims to have had sex with prostitutes more than 50 times and has had sexual contact with 20 women, seven of whom were virgins. He has given up prostitute patronage three years ago from fears of getting AIDS. Instead, he has become sexually involved with many non-prostitute women in the past few years. He is confident that these women are not prostitutes because none demands that he pay money or gifts. He is also confident because he knows the background of these women. Some of these women are married but have had sexual affairs with him from attraction. He hardly ever uses condoms with these non-prostitute women because he is confident that these women do not have sex with several men at a time. He has given a blood donation recently so he believes himself to be AIDS-free. His latest sexual intercourse was with a restaurant waitress. He has been STD infected several times but he is not threatened by the infections since they can be easily treated. He claims that some of his friends most of whom are overseas workers have implanted penile pearls to sexually arouse their partners. This kind of penile operation was once popular among manual labourers. It is becoming rare but is still popular among many prisoners.

Women's life stories

CASE 1 (single woman with multiple partners)

Ton is a final year university student aged 26. She comes from a middle class family with no financial hardship. She moved to the city for tertiary education several years ago. Her parents who are both school teachers financially support her and her brother who is also a college student. She lives alone in an apartment since she first started the university. She appears more affluent than her friends, owning a car given by her parents.

Her boyfriend who is four years her senior comes to stay with her at the apartment every weekend. He pays the rent so she can use her parents' allowance for other expenses. She has had sex with her boyfriend for almost four years since she first moved to the city. Her boyfriend never uses condoms with her. He uses *coitus interruptus* to prevent pregnancy. She perceives nothing wrong for single women to be sexually engaged with their boyfriends as long as they are both responsible for their behaviour and women are protected from pregnancy. She claims that many of her friends live with their boyfriends just like her. She feels no guilt and is no different from other friends about premarital sex.

Besides this boyfriend, she occasionally has sex with a female friend. This girlfriend has sex with several women other than her. She claims that she has sex with women to try the difference only. Other than her boyfriend and girlfriend, she has a sexual affair with a businessman who is 12 years her senior. This senior boyfriend takes her out for dinner and gives money to her many times. She had her first sex with him after a few months of knowing him. She knows that this man has a family and he knows also that she has a boyfriend with sexual relations. However, neither of them could terminate their sexual affair. They have no commitment with their sexual engagement. Her senior boyfriend uses condoms with her most of the time, except when he is drunk and loses control. Her boyfriend is not aware that she has an affair with a woman and another man. She plans

to terminate the relationship with the others and would like to marry her boyfriend after graduation.

CASE 2 (single student with sexual experience)

Oon is a fourth year university student aged 22 who comes from a province in the central region. Her parents separated when she was a baby. She had been living with a grandmother before moving to Chiang Mai. Her father has remarried, but she does not get along with her step-mother. She is financially supported by her father and an uncle.

Oon claims that she used to be a very conservative woman until she met her boyfriend in her second year at the university. She knew her boyfriend for over a semester before they had the first sexual intercourse at a friend's place. She did not want to have sex with him at that time as she was afraid that she might lose her value. However, after the experience of first sex, she had become sexually engaged with her boyfriend many times from fear of losing him. She does not take birth control pills because she is too embarrassed to buy them. To prevent pregnancy, her boyfriend occasionally uses condoms with her, or they have sex during the 'safe period'. She claims that her boyfriend is careless about her feelings and seldom makes her reach climax. She never complains to him about this since she feels that there is no need for women to be sexually fulfilled. She wants to have a family with him after graduation as she no longer wishes to be dependent on her father. With disappointment, she has found recently that her boyfriend has been sexually involved with another woman who lives in another province. She claims to have won her boyfriend back by pleasing him with techniques of sexual intercourse that she has learned from books and magazines. Although she feels ashamed in doing it, she believes that this is the only way to keep her boyfriend with her. She would like to abstain from sexual intercourse with him from fear of getting AIDS, but she is not able to do it because her boyfriend might turn to other women. She believes that her boyfriend has not had sex with prostitutes in the past few years because he is sexually satisfied by her. They plan to live together after graduation.

CASE 3 (single student with a boyfriend)

Dang is the second daughter of a farmer family. She has a sister and a brother. She describes herself as an obedient daughter who always follows her parent's suggestion. Her parents do not like her to be away from home at night. While living with parents, she usually has to be home by 6 pm. She moved to live with a relative in town for high school, and met a boyfriend. Although they have known each other for a long time, she only allows her boyfriend to hold hands when they are together. She feels that she should be conservative because her parents have a difficult time finding money to support her education. Her family has high expectations of her. Her parents dislike her boyfriend so she feels that her relationship with him should not progress. Her boyfriend has a job in Chiang Mai now so they meet often. Unlike some friends, she does not want to be sexually engaged with her boyfriend before graduation. She believes that it is still a common practice for men to gain sexual experience with prostitutes before they turn 20.

CASE 4 (single student with partner)

Ning is a third year university student aged 21. She has one younger sister who is in high school. She claims to be a conservative person as her family is very conservative. She met her first boyfriend when she moved to the city for university education. She did not see him often because she was too nervous about her study then. She met another boyfriend in the second year through a circle of friends. They became close after a year of knowing each other. She was forced to have sexual intercourse with him before he transferred to another university in Bangkok. After the first experience, they had sex many times since they expected a marriage after the graduation. To prevent pregnancy, he uses *coitus interruptus* or she takes morning-after pills. After intercourse, she inserts a finger to clean inside her vagina with soap; she believes that the sperms can be destroyed easily by soap since they are fragile cells.

As their relationship grows, she feels that her boyfriend only needs her for sex. He comes back from Bangkok every weekend so to have sex with her. His parents have limited his allowance to prevent him from visiting her so she goes to see him in Bangkok sometimes. However, she later found that her boyfriend has been sexually involved with another woman. She finally terminated her relationship with him and has met another boyfriend a few months after. Her current boyfriend believes that she is still a virgin. They have had sexual intercourse a few times and he expects to marry her after graduation. She is afraid that her current boyfriend might look down on her if he knows that she has had sexual intercourse with another man before.

She is afraid that she may be at risk of getting AIDS since none of her boyfriends has ever used condoms with her. She knows that her first boyfriend has had sex with prostitutes several times. However, she feels awkward to have an HIV blood test and is embarrassed to ask her boyfriend to use condoms with her.